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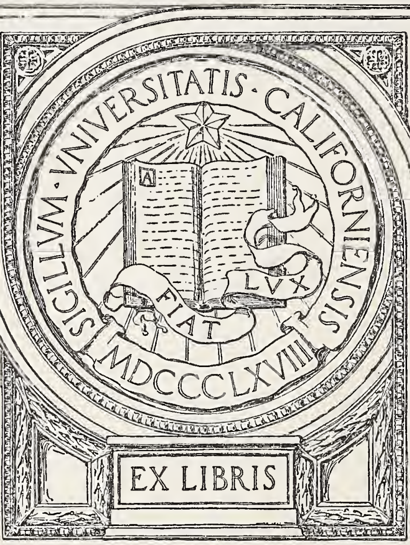

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[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

THE CHARITY HOSPITAL FROM 1877 TO 1894.*

BY W. E. PARKER, M. D., VISITING SURGEON, CHARITY HOSPITAL, NEW ORLEANS.

Mr. President and Gentleman: I regret that I should appear before you with an apology. It would have been a pleasure to have started my chapter of hospital history where one honored and industrious president left off, but as I did not know that I was to appear before you with a paper until your program was out, it was necessary for me to take a period during which the records were accessible. It is a difficult matter to write an unbiased history of times during which we live and in which the three surgeons who guided the institution of which we write could be called friends by the writer. The period of which we write was probably the most eventful in the history of the hospital.

In 1877, the finances of our State were at a low ebb as a result of "carpet-bag" misrule, and it is of interest to note the conditions existing when the first Nicholls board went into office. The main building and such others as were then in existence were in wretched repair, and there was not even a change of bed clothing for the patients in the wards. It is of interest to take a few notes from the last report of the preceding administration. During that year, 6215 patients were treated. The warrants issued by the State had been sold below par and the hospital not only did not have the money to pay its honest debts, but had a floating debt of more than $72,000, and its credit was gone. All of the money due on this floating debt was, as shown by an itemized table, for legitimate expenses, and it is stated that of the amounts unpaid, $23,108.69 was due the butcher, with large amounts due for drugs, bread, etc. Such was the condition of things when the present Chief Justice, F. T. Nicholls, was elected Governor of the State.

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*Read before the Alumni Association of the Charity Hospital of Louisiana.

He appointed an excellent board of administrators of which Dr. A. C. Holt, a distinguished physician at the time, was vice president, and the Hon. M. D. Lagan was chairman of the House Committee. The members of the board were all prominent in business and professional circles, and deeply interested in the hospital.

When they met for an election of house officers, Dr. A. B. Miles was elected assistant house surgeon, but there was no election for house surgeon, as the board was deadlocked between Drs. A. W. Smythe and Geo. K. Pratt. Four days later Governor Nicholls attended a special meeting of the board and cast the deciding vote for Dr. Pratt.

After organizing, the first thing was to try to get the hospital on a better footing. The hospital being without money, the chairman of the House Committee had to guarantee the hospital accounts for supplies. No report was published of the first year's work of this board for the reason that the hospital had not the money and the State refused to do it. However, the debt was wiped out and improvements were made. To do this there was a general reduction of salaries and expenses. At this time the salary of the House Surgeon was but $1800, and that of the Assistant House Surgeon but $1200. Among the improvements made at the hospital the following may be mentioned: The walls and galleries which were about to fall were bolted; hot and cold water supplied to the wards; seventeen new cisterns, of a capacity of 240,000 gallons, were added; new ventilators were put in and an elevator. Puerperal septicemia, which had been a scourge, necessitated a separate lying-in ward, and the board, out of their scanty revenues, saved enough to erect the present A. C. Holt obstetric ward. This board wiped out the floating debt and made the improvements above mentioned, and must be credited with laying the foundation of our present well-regulated institution. While much was left to be done, the more urgent things were attended to, and the hospital was no longer a place for political gatherings, but simply a medical and surgical institution.

After the Constitutional Convention of 1879 Governor Nicholls' term expired, and Louis A. Wiltz was elected Governor, a new board was appointed, and Dr. D. C. Holliday, a man of large experience and influence, was elected vice president, Dr. Edmond Souchon was appointed chairman of the house committee and Dr. de Roaldes elected house surgeon, and Dr. A. B. Miles assistant house surgeon.

Among the changes of especial interest during this administration the following may be mentioned: The resident students, who until this time had been appointed by influence, were required to stand an examination for admission, another at the end of the first year to stay in, and a third at the end of this term to see if they should get a hospital diploma, which until this time had not been awarded them. The necessity for a training school for nurses was strongly pointed out, and arrangements for it made. Although the then House Surgeon, Dr. A. W. de Roaldes, and the Board of Administrators always denied any such intention, the impression was created that it was an effort to remove the Sisters of Charity, and the movement was vigorously opposed by them. A building was bought and a chief nurse secured, but the school was never put into operation, as the board was removed by Governor McEnery, who became Governor in 1881, when Governor Wiltz died. This administration, like the one before it, had to economize on account of the great discount on its warrants. However, the general condition of the hospital was in many ways improved, and suggestions as to other needed improvements were made. Notably among these was the necessity for increased space for the negro service, new iron beds instead of the old wooden beds in use at the time, increase of the usefulness of the pathologic department, and last, but by no means least, a sewer pipe from the hospital to the river. Plans were also drawn for an ambulance service, much on the lines of the present service.

In 1880 Dr. A. B. Miles, resigned the position of Assistant

House Surgeon and Dr. Marks Levy was elected to fill the vacancy. This board did excellent work in many ways, but did not have the money or length of service to carry out some of the improvements that they had in view. During this administration, Mr. John Burnside willed the hospital $10,000, and Mr. Charles E. Schmidt $500. Their names are properly marked on the tablet in the hall of the main building. This board was removed from office in 1881. When the new board appointed by Governor McEnery came into office, Dr. A. B. Miles was elected House Surgeon and Dr. David Jamison was elected Assistant House Surgeon. Dr. Miles declined the election at first, but accepted when the board increased the salary of the House Surgeon to $3000 a year, and that of the assistant to $2000. The hospital had gradually grown in importance, and was in a very crowded condition. It was thought if outdoor clinics were started it would relieve the congested indoor service, so this was done. The relief afforded to the wards proper enabled the House officers to use a ward, formerly an eye ward, for a separate ward for boys, and another ward as an additional ward for negroes. During the first year of this administration, the present elevator was put in, five new cisterns, with a capacity of 100,000 gallons, were added, and the ventilation improved. The work of the pathologic department was increased. In the report of 1883 the bad sanitary conditions were again pointed out. It was pointed out that there were 100 more beds than the cubic air space warranted, and that there was indiscriminate grouping of cases, specially in the female wards. In the white wards medical and gynecologic cases were grouped together, and in the negro wards medical, surgical, gynecologic and obstetric cases were indiscriminately put together. A separate building was strongly urged and was provided for by the Board. In the report of 1884 we find the ambulance service started, the building for women and children completed and the long urged sewerage system laid and in operation. A new pathologic department was also built, the old one having been on the site of the present building for women and children. It is of interest to note that of the funds necessary for these improvements, $33,000 was contributed by citizens and the police juries of parishes, and $37,323.86 contributed from an amount saved out of the general fund of the hospital. Through Senator

McEnery (then Governor) the Fournier clock, which had been on the old State House, now the Hotel Royal, was given to the hospital and put in the building for women and children. The new building for women was opened August 25, 1884, and the pathologic department September 1. During this year the present female eye ward was added. Extensive improvements were also made in the kitchen. The warrants issued to the board at this time were not promptly paid and were at a discount. To save this the members of the board individually and as a board borrowed $43,700, for which they gave their personal notes. During this year Mrs. Charlotte Piffet willed the hospital $3000, but as a result of a lawsuit the amount was cut down to $1800. In 1885 the present ambulance house was built and new quarters provided for the resident students. Until this time the resident students had occupied the present mess rooms at the ends of the halls of the main building. During this year Dr. David Jamison resigned as Assistant House Surgeon, and Dr. F. W. Parham was elected in his place. At this time puerperal fever was still raging in the obstetric wards, and to Dr. Parham should be given the credit for having stamped it out, as we believe, forever, as a prevailing disease at the hospital. During this year Jules Cassard and Mrs. Caroline E. Simms left legacies to the hospital. The hospital bought the electric apparatus and started the present electric room.

In 1886 the Legislature passed a law limiting resident studentship to citizens of this State. In the report for 1887 was a strong recommendation that this law be repealed, and this was done. The classes of graduates of 1889 and 1890 were admitted under this law. In 1887, Dr. H. W. Blanc, at that time dermatologist to the hospital, called attention to the fact that twenty-two cases of leprosy were being treated at the hospital and recommended that some provision be made for these cases. Although these cases were treated in the wards with other cases and were in the hospital for five or six years, no known case developed among the other patients. This is a strong argument against the popular belief that this disease is very contagious. In 1888, Governor Nicholls again became Governor and appointed a new Board of Administrators. At the election of officers following the organization of the board, Dr. J. D. Bloom was elected to succeed Dr. Parham as Assistant House Surgeon.

On December 3 of this year, Dr. H. D. Schmidt, for many years the pathologist, died. He was a profound scholar, and although for many years he had been an invalid from rheumatoid arthritis, his work was remarkable. Deformed in all of the joints of his hands and unable to walk, his sections of pathologic specimens were perfect and the brains injected by him and now in the museum of the University of Pennsylvania will always show his wonderful workmanship. Gentle of manner, it was always his pleasure to assist the medical student. In the succeeding year the principal change of interest was in regard to appointments on the Board of Administrators. Instead of each new Governor appointing a full board at once, two vacancies occurred each year. This to a large extent diminished politics in the board and insured experienced men on it.

In 1890 two new operating rooms were added to the old amphitheatre. Until that time only one operation could be done at a time. Until 1891 the outdoor clinics were held in the wards, which necessarily caused confusion, but during this year the present model outdoor clinics were built. During this year the heirs of N. H. Letchford gave the hospital $1000, and Jean F. Switzer, who, although a Louisianian, had lived in France, gave the hospital $20,000. 1892 was specially marked by deaths on the staff. January 11, Prof Samuel Logan, vice president of the board, for many years on the visiting surgical staff and a prominent practitioner, died. He was an able surgeon, a man of fine judgment, a good teacher and energetic administrator. He was followed by Dr. J. H. Windahl, who for several years had been an able administrator. In December, John Johnson, for over thirty years connected with the drug department, died. At the age of ten he ran away from his home in Denmark to come to this country, and on the way over broke his leg. When he arrived he was sent to the hospital and it was subsequently, his home. When he recovered he was put in the drug store to wash bottles. During his odd moments he studied, and when but sixteen years of age was made assistant druggist. In 1872 he detected the druggist swindling the hospital and reported the facts. It was investigated by the board and the druggist was dismissed. He was then elected druggist, and with the exception of a short interval, continued to fill the position until his sudden death. For many years he was a systematic and enthusiastic student. Later he allowed himself more time for pleasure. At the time of his death, he had become the foremost chemist of the State. He was a man of peculiar temperament, but a loyal and true friend and a man who was an interesting study to those who knew him.

In this year the pay ward, which for many years had been a source of revenue to the hospital, was abolished. For a long time the members of the medical profession in New Orleans had felt that it was an injustice to have this ward in an institution supposedly for paupers, and when they served on the visiting staff without renumeration. However, the immediate cause of abolishing the pay ward was an attack made on the hospital by a former patient, who wielded a good pen. As a matter of fact, this patient, a writer for one of our local dailies, had been dismissed from the hospital for calling one of the sisters a vile name, because she insisted on taking some newspapers, etc., from the ward at night and having the ward straightened up. The attack would never have been published had the editors of the papers known the facts. On the 22d of May, Dr. T. G. Richardson, for over thirty years a member of the visiting staff and professor in the medical faculty of the university, died. Of commanding presence, he was a giant among men, mentally as well as physically. He had fine surgical skill and judgment, and was an able teacher. Among his many honors, he had been president of the American Medical Association.

In 1893, the training school for nurses was established, iron beds were put in to replace the old-fashioned wooden ones, and the hospital generally was refurnished. Plans were made for the present A. B. Miles amphitheatre, and arrangements for it started. Among the suggestions specially urged was a more accurate keeping of the archives, and for a Charity Hospital bulletin. In 1894 the present amphitheatre was well under way, when Dr. Miles became a victim of typhoid fever, and on August 4, 1894, died as a result of intestinal hemorrhage. This most interesting character was born in Bathville, Ala., in 1852. During the war, he moved to Texas, where his parents died, and he then lived with an uncle in Arkansas. Space does not permit an extended sketch of him, but he came to New Orleans in 1872 to study medicine, and became the pupil of Professor Samuel Logan. In 1873, he became a resident student in the hospital, and from that time was markedly identified with it. He had a thorough knowledge of anatomy, rare skill as a surgeon, and remarkable surgical judgment. Of an attractive personality, he was a man of and leader among men, and had remarkable executive ability. Men of his calibre are rarely seen. He met death fearlessly, although but in his prime, and died mourned by the entire community. Tracing the conditions in these seventeen years, we see instead of a building about to fall down, a building in good repair and with all modern conveniences. Instead of a debt, we find that notwithstanding the extensive improvements, there was a large surplus, and in this time the work of the hospital had increased so that for 1894 there were 9850 admissions and 19,945 treated, with a total of 68,727 consultations in the outdoor clinics. Surely the boards during this time, and the surgeons in charge, can look to the records with pardonable pride.

ADDRESS BEFORE THE ALUMNI ASSOCIATION OF THE CHARITY HOSPITAL OF LOUISIANA.

BY REV. BEVERLY E. WARNER, NEW ORLEANS.

If we date the real foundation of the Charity Hospital back of the large-hearted Spaniard whose dust lies still honored in the St. Louis Cathedral, to the humble sailor, Jean Louis, of whom Bienville wrote as early as 1737 as leaving a small sum of money to found a hospital, we find that it is almost our oldest public institution of any sort. A community can have no finer heritage from the past than this. We know what those early days of colonization were. It was by no means wholly a golden age of noble quest for new lands, and the conversion of heathen peoples. I am inclined to doubt if a single royal patron of those fifteenth and sixteenth century explorers thought very much of the souls of the aboriginal Americans. I imagine if we could get at the real inspiration of those who followed westward ho, in Columbus' track, we would discover that the conversion of Indians to slavery went along, *pari passu*, with their conversion to Christianity. The student of that early history knows well that gold was the great incentive, that the greed for gold and the restless spirit of adventure crowded both deck and cabin of the adventurer's frail ships. Even after a more settled colonial life began, the colonies were for a long time convenient points of exploitation, where younger sons, black sheep and the outlawed generally were turned loose in large numbers for the mother country's good.

It is to the glory and credit of the early Louisiana colony that, with the temptations and allurements of an environment which must have been in parts such as this, one of her first institutions was a hospital which, though founded by the benevolence of one poor man, was taken up as a public charge and cared for after the fashion of the day as a sacred trust. A perusal of the interesting and instructive pamphlet by your president, Dr. J. J. Castellanos, on "The Early Charity Hospital," betrays the fact that your alma mater shared fully in the tribulations of that undulatory period of Louisiana's history. One might have been born in France, reared in Spain and become a full citizen of the American republic, during that time, without ever crossing Canal street. It was truly a picturesque jumble of civilizations, but it had its drawbacks.

We have some of the latter to-day. In a few instances we have not yet crossed Canal street. We are sure, however, that that passage is only delayed for a time as we stand on the neutral ground to take our bearings. The Charity Hospital has ever been the meeting point, however, where a wise conservatism and a judicious liberalism have joined hands with one common object—the amelioration of physical suffering and the triumph of knowledge over ignorance, or light over darkness. Every age has its own special message and mission to the men and women who listen to the clearest voices and seek to perform the highest things. But through all ages one note has ever grown clearer and higher; one message has met with wider, more sympathetic and more intelligent response. In these days this note has deepened and broadened into the full harmony of the human octave. It is that of helpfulness and ministration to human need.

From one point of view, indeed, and on the surface, it would almost seem that the last quarter of the nineteenth century had been given over to and swallowed up by the magnitude of materialistic developments; that the discoveries, inventions and applications of the physical sciences were ultimate links in an immutable series of the divine order. It is an age, so to speak, of glorified mechanics. And yet we perceive, if more than superficial observers, that no step in advance has been taken, however materialistic it may seem, that has not and does not minister in some way to the needs, the service, the betterment of man. Physical science is not the whole Gospel, while it does form a splendid part of its message. If we have flowered, somewhat exclusively in these last few decades, into the brilliant productions of the laboratory and crucible, it is only because this is the result of a natural evolution in human progress.

The Elizabethan era did not forget or belittle spiritual things, because in that day the Divine Order blossomed into the most brilliant literature of all time and took form in new nations beyond the sea. God was not forgotten because Shakespeare interpreted Him, nor am I persuaded that He is neglected because Darwin and Spencer and Edison have uncovered to our eyes processes of His working hidden to Bacon and John Milton. Science the stumbling block of the Divine? Nay, it is the handmaid and interpreter. We do not know what message may be withheld from us for the ears of the coming generations. We can only believe that through it all "one unceasing purpose runs," and that the larger knowledge which may be, the clearer light that must be in the future, will never minimize the truth seeking of this age. Nay, more, we must know that the very condition of larger knowledge and clearer light hereafter is the faithful living up to the knowledge and the light we have to-day. So no age abides in the trenches of its own achievements, but is endowed in trust for each succeeding age.

Above all other vocations that of the physician and surgeon seems to be the superb flowering of materialism. The surgeon stands over his patient with knife and instrument. He is intent on the body before him. On the one side he seems pure-minded, working in the realm of pure matter with conscious superiority. But no one knows better than the minister to men's bodies that he must take into account far more than the flesh and blood before him. Heredity overshadows him; environment is at his elbow; every movement is made with the keen sense of the awful fact that he is dealing with ghosts of the past and of the future even on the physical side, and that on the spiritual side, for which he has no rules in the books; he must be instinct with care for the bodies of men as being more than bodies. The good physician, whatever his special calling, is not only incarnate mind, he is incarnate love. Sometimes he may not realize this, but it has been realized for him out of the experience of the past; and the difference between the modern hospital, with its appurtenances for the whole man, body, mind and spirit, and the ancient medicine man with spells and amulets and bloody charms is the difference between the midnight and the dawn. We grow into our heritage of love and care for helplessness and need, so slowly and so naturally, that we are amazed now and then when a monument is set up, causing us to look from its pinnacle down and back upon a past that seems incredible.

One of the finest of the pagan nations thought so little of lives that did not promise leaders in camp or on the battle-field that they exposed them to die from the very womb. Only the other day the Charity Hospital opened a great and splendid building devoted to the care of children only. The Spartan civilization said to the weakling, "Die and be done with it; we will nurse no weaklings to cumber our homes or weaken our armies." The Milliken Memorial—all honor to the noble heart to whose inspiration we owe its superb benefaction—the Milliken Memorial, uttering the voice, not of one tender heart alone, but of this Christian civilization, cries abroad that the tiniest body wherein resides the spark of life is sacred; that the puniest frame has the rights of the strongest; that the offspring of a degradation for which it is cursed but not responsible shall have the care of a child of an untainted holiest love; and within those walls the babe, whimpering with pain it can not express, shall be hushed into the peace divine of body and soul—because, because, life is an awful gift of the Creator of the Universe, and we have learned that He hath a purpose even in the babies and sucklings, even when in these antechambers of the eternal—their office only seems to be to suffer and to wait.

The hospital stands for something more, however, than mere helpfulness to human need. It is the most highly organized helpfulness. The dear old doctor of the past, with his hospital on horseback, and his operating room in his saddle bags, did represent, and does represent truly in very many localities a genuine ministration to the ills the flesh is heir to—but whatever his skill and devotion to his calling—and the country doctor adorns a splendid page in the history of the profession—he could not and can not be the same force on his lonely rounds as he could be with the hospital at his back.

The Charity Hospital of this city is a standing witness to the fact that the true physician recognizes this first of all, and those wards and beds yonder know no section and no locality, in bearing their burdens of need. Good work is good work all the world over, but organized good work is best. The peculiar dominant characteristic of this time is what we call co-operation. It already shows signs of breaking down in some lines, where it has been abused. But it has never been abused by the doctors. There are no trusts in surgical implements. Dr. Koch gives his hard-earned discoveries a free gift to the world, and the hospital is the co-operative monument carried to its highest power along the line of ministration. What the millionaire may not have in a country village, the poorest or the richest may have in the hospital, and the poorest as freely as the richest. What one could not afford 10,000 may have without cost to themselves. It is true that without skilled physicians and surgeons, all the appliances of ancient knowledge or modern discovery would amount to little. It is equally true that the skilled operator may and does often from necessity work with limited appliances and poor tools, but when we seek the best results how finely it speaks for the community that the best results are demanded for the poorest; we seek the co-operation of the highest skill and the best tools. The hospital is thus the best synthesis in this age of all that is best known, and known to be best for the repair, the recreation and the amelioration of man's physical disabilities. I can not fail in this connection to speak of one other feature of the modern hospital, which, a generation ago, was not only practically unknown, but had to fight its way to recognition.

Skilled as a physician or surgeon should be, abundant as their resources were, potent as their medicines and magical their apparatus, they were often hampered even in the hospitals by lack of skilled assistance. Many a battle hardly won was lost by the nursing care, which, however affectionate, was ignorant, and therefore dangerous. Every physician before me knows that his uttermost skill is often made of no avail by the environment of his patient. It is the one hopeless and discouraging element in a calling which with all its responsibilities has more in its practice to inspire and encourage than any other profession.

In due time with, and as a necessary supplement to the perfectly equipped hospital, the trained nurse took her place at the bedside, and what would be often defeat is turned into victory. Blucher at Waterloo was no greater re-enforcement to Wellington than the cool-headed, active-handed trained nurse to the sore-pressed physician. She added the last necessary element in the cool co-operation of man against the foes of disease and death. She was not greeted cordially save by a few. Alarmed love was in arms against her from the first. It only grew slowly into people's minds that their affection was no more competent to nurse than to diagnose a case, and that a paid nurse was no more of a reflection upon their family solidarity than a paid doctor. Conservatism, the natural foe of new ideas, but the natural protector of ascertained truth, was necessarily slow in giving way. But I think we may say that the storm and stress period is over, and that the trained nurse is now an acknowledged factor in the problem of easing the world's pain and hushing its cries of anguish. We have yet one step to take, not only here but elsewhere, to provide from the great hospital, corps of trained nurses whose work shall lie outside the walls of the institution, who will be maintained by public funds, to be at the call of any physician to take her place at the bedside and in the homes of the destitute. It will supplement and simplify your task, and your many burdens, and mean much, I am persuaded, for the general public health and comfort. Moreover, it will be the natural, scientific and logical extension of the hospital service.

But enough of statements, which can not but seem trite to your ears, and suggestions, which probably have occurred to the minds of many. I am most happy to have the opportunity of greeting and addressing this representative body, and of expressing my sense of the value of the institutions whose name your organization bears.

The single doctor might be a voice crying in the wilderness, however true his note, and clear his message. The associated brotherhood is something more. You stand in serried ranks, gifted with a fine enthusiasm, endowed with the authority that numbers and experience give for some of those truths that seem to me utterly and beyond all question divine; that disease is the child of disorder to be reduced to order; that pain is a hateful thing to be expelled from life; that sickness is unnatural, not natural; that man was never created to be a gnarled and twisted monstrosity, but an upright image of the God who made him; that plague and pestilence and epidemics are not unexplainable visitations of malignant spirits, still less dispensations of an all-wise Providence; that we are no longer justified in labeling the yellow fever or small-pox, which results from our own stinginess, carelessness or obstinacy, as the will of God.

Why?

Time was when men did not know. And when the plague swept across the nations, decimating tribes and families, they could honestly look upon them as arbitrary visitations for national or individual sins. So they lifted their eyes above the garbage and sewers and filth in which they ignorantly wallowed and poured out their souls in litanies and prayers. And those prayers have been answered. Not in the sense of being charms to produce magic or miraculous effects, but in the way of opening men's eyes to discern that the causes of disease were largely within their own control. Slowly the perception dawned. Men grew to see that they reap as they sow. The present sunshine of physical science and sanitary knowledge is an answer to the litanies of our forefathers. We know that the pestilence is the result of violated law.

This is your message to a world that for all its civilization and culture is still apt, from time to time, to stray away—after false gods—and raise new altars with strange names. As long as we have people who are seeking the secret of a perpetual motion, who toil terribly to get something out of nothing, and insist that a carbuncle is only a vibration of thought, so long we will have the quacks and charlatans by whatsoever high-sounding names they may call themselves, who will fasten upon those soft spots in the body politic and suck what blood they may.

But I am no pessimist. The world is growing better. Men are growing better. And if we are to be plagued for our sins by the guerrilla horde of those who batten on the weaknesses of humanity, so we are blessed in that guild and brotherhood whose calling is less than any other perhaps tempted to prostitution by the gods of the market place, whose choicest reward lies not in the silver and gold, but in the tears and smiles and love of men and women, whose bodily pain they have eased, and whose ideal of life, come what may, must ever be. "Greater love hath no man than this, that a man shall lay down his life for his friend."

EXPERIMENTS PERFORMED AT THE CHARITY HOSPITAL OF NEW ORLEANS AND ELSEWHERE, WITH SANARELLI'S ANTI-AMARYLIC SERUM IN THE FALL OF 1898.*

By P. E. ARCHINARD, M. D., Professor on Diseases of the Nervous System and Clinical Microscopy, New Orleans Polyclinic; Bacteriologist to the Louisiana State Board of Health, etc., New Orleans, La.

Early in 1898, we received nearly 100 20 *c.c.* doses of Sanarelli's serum from Monte Video, with the request of the sender that we experiment with same and report results. In the fall of 1898, yellow fever again appeared in New Orleans, and the opportunity was offered of trying this new agent in yellow fever. The fever cases at the Charity Hospital were kindly placed at our disposal by Dr. Bloom, house surgeon of the Charity Hospital, for the purpose. Drs. Fenner and Batchelor, assistant house surgeons of the hospital, lent us their help in many ways, the latter, especially allowing us the use of notes of the cases under his immediate supervision for our guidance. Dr. Nelkin, interne of the hospital, since then a graduate, helped us very materially in our work, and took detailed notes of the cases under observation. The experiments were tried in fourteen cases—eleven cases in the hospital and three mild cases in private practice.

Case 1.—R. S. Davidson, taken sick on September 25, 1898; admitted to the hospital on the morning of the 26th with a temperature of 103, pulse 100; developed all the clinical symptoms of yellow fever from that date to September 30 in the evening, when first seen by me. His facies was characteristic; temperature 105 deg.; pulse, 100; delirious; jaundiced skin, spongy and bleeding gums, urine diminished in quantity and albuminous, constant projectile vomiting, vomit black. Injected 20 *c.c.* Sanarelli's anti-amarylic serum into loose tissue of lumbar region. That night his temperature fell to between 102½ and

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*Read at Louisana State Medical Society meeting, May 1899.

103 deg., pulse 85; he was delirious at times, but rested more quietly; vomiting still continued.

On October 1, in the morning, his temperature was 103$\frac{3}{5}$ deg., pulse, 85; symptoms the same as the day before, urinated about the same, urine still albuminous; in the evening his temperature fell to 101 deg. and his pulse went up to 95; still vomiting.

October 2., A. M., temperature, 100$\frac{4}{5}$ deg., pulse, 90; delirium more intense than the day before; urine diminished in quantity and albuminous; injected 20 *c.c.* Sanarelli serum. P. M., temperature, 101 deg.; pulse, 92; violent delirium; vomiting continuous; patient is getting very weak.

October 3, A. M., temperature, 100½ deg.; pulse, 110; patient is sinking. He died at 5:30 P. M.

CASE 2.—Jacob Salvador was taken sick at 8 A. M., September 28, with chill, severe headache and pain in the back. Admitted in hospital on September 29, A. M., with intense backache and headache, flushed face and injected eyes; tongue red, epigastric tenderness and nausea. Temperature remained at about 104 deg. all that day; pulse, 100. Ice-water enemas given without any effect on temperature. Urine one-half pint in twelve hours, slightly albuminous.

September 30, A. M. temperature 103$\frac{4}{5}$ deg., pulse 100; vomiting freely. 5:30 P. M., temperature, 105, pulse 90, vomiting still continuous; gums soft, spongy, bleed easily on pressure. Injected 20 *c.c.* Sanarelli's serum.

October 1.—Temperature fell at 2 A. M. to 103 deg., pulse 90, still vomiting; urine contains 4 per cent. moist albumin; skin more jaundiced. P. M. temperature 104 deg., pulse 90, condition much the same as in the morning.

October 2.—Constant vomiting during night; temperature 103$\frac{3}{5}$ deg., pulse 80, urine diminished in quantity, urine highly albuminous, slight delirium. Injected 20 *c.c.* anti-amarylic serum. P. M. temperature 104 deg., pulse 75, urine greatly diminished, albuminous; vomiting still continuous, projectile, black.

October 3.—Temperature 102$\frac{3}{5}$ deg, pulse 72, constant black vomit; can not retain nourishment; bleeeding gums; constant delirium. P. M. temperature 103 deg., pulse 80; all symptoms aggravated, almost total suppression of urine.

October 4.—Patient comatose, died 5 P. M. in convulsions.

CASE 3.—Nick Caramando was taken sick with pain in stomach and vomiting, fever, but no chill, on September 25. He remained at home in bed until the morning of September 28, when he was brought to the Charity Hospital. He had high fever, intense headache and backache, a congested face and suffused eye, red tongue, soft gums; temperature, 103⅖; pulse, 72; he vomited very often and passed very little urine, showing 18 per cent. of albumin.

On September 29 his condition grew worse.

On September 30, at 5 P. M., injected 20 *c.c.* Sanarelli's serum; temperature was then 102⅗ deg.; pulse, 75; vomiting was almost constant; gums were bleeding.

October 1.—Temperature ranged between 102 and 103 deg.; pulse between 70 and 80; vomiting still continuous; intense jaundice; gums bleeding; urine very scant, albumin 25 per cent.

October 2, A. M.—Temperature, 103 deg.; pulse, 100; patient delirious; vomiting black; given 20 *c.c.* Sanarelli's serum. P. M.—Temperature, 103⅗ deg.; pulse, 130; intense delirium, convulsive movements at times; complete suppression of urine.

October 3, temperature 100 deg.; pulse 140; vomiting black; delirious. 4 P. M. general convulsions, followed by coma and death at 10 P. M.

CASE 4.—Female, Ward 40, in eighth day of disease; case had been a moderate one and had run a natural course; symptoms had all subsided, except the slow pulse and albuminous urine. Injected, September 29, 20 *c.c.* serum to test its efficacy on the urinary secretions; no appreciable increase of urine and no diminution of albumin—no untoward symptoms followed the serum administration.

CASE 5.—James Stuart, laborer, aged 42 years, born in Scotland; in New Orleans nine years; an alcoholic; was taken sick October 17, 1898, with a chill; pain in the back and legs; intense frontal headache, pain in epigastrium and vomiting. Was admitted in Charity Hospital on October 19, at 11 A. M., with all the characteristic symptoms of yellow fever; temperature 104 deg., pulse 80; urine scanty, dark color: 8 ounces passed in first 12 hours in hospital; specific gravity 1.014, about 2 per cent. albumin. Injected 20 *c.c.* Sanarelli's serum; continued vomiting all day; could retain no nourishment.

October 20, morning temperature 101⅘, evening 102; pulse

82–78 respectively; patient mildly delirious and apathetic; passed in 24 hours 1 quart urine, with 5 per cent. albumin.

October 21. Temperature fell to normal, pulse 70; patient very much jaundiced, gums spongy, bleed easily on pressure; vomiting continuous; urine 30 ounces, albumin 4 per cent; patient's mental condition not improved.

October 22. Return of fever, temperature went up to 101 deg. in the evening, pulse 80, vomiting continuous; injected 20 *c.c.* Sanarelli's serum; urine 28 ounces, albumin 5 per cent.

October 23. Temperature went up to 102$\frac{3}{5}$ deg., pulse 90; retention of urine; amount voided in 24 hours 35 ounces, albumin 30 per cent.; vomiting black; gums bleeding freely.

October 24. Condition much the same as day before. This case continued in an asthenic condition, developing signs of distention of the bowels which gradually grew worse. The amount of urine diminished in quantity and had to be drawn from him until it became totally suppressed on November 1, when he died.

CASE 6.—Mike Grazer had been sick two days when admitted to the hospital on October 4. His face was flushed, eyes injected, temperature, 103$\frac{3}{5}$ deg.; pulse, 110; was given immediately 20 *c.c.* of serum.

October 5, A. M. Temperature, 101$\frac{2}{5}$; pulse, 100; evening, temperature, 104; pulse, 116; diffuse redness of body; no vomiting; no epigastric tenderness; no delirium; urine rather free, non-albuminous.

October 6. Morning, temperature, 101; evening, 103$\frac{2}{5}$; pulse. 96 and 110; headache, but no other symptoms; at night he vomited his medicine containing phenacetin, but otherwise stomach has been undisturbed; urine free from albumin; five grains of quinin were administered every three hours until evening and the consequence was, the next day the temperature fell to normal and remained there that day; was able to get up on October 10 and left the hospital on October 13, with a diagnosis of *malaria* written on his ticket.

CASE 7.—Wm. Davis, aged 23 years, was taken sick on October 19, with chill, fever, slight headache and backache, face flushed, eye injected, tongue pointed and red at tip.

October 20. Symptoms more marked, epigastric tenderness, vomiting, temperature 104 deg., pulse 110, flushed face, capillary stasis, injected eyes, urine slightly albuminous; injected 20*c,c.* Sanarelli's serum.

October 21, A. M., temperature 104 deg., pulse 105, gastric embarrassment more marked, intense headache, great prostration, urine free, albuminous; P. M., temperature 105, pulse 102, symptoms same as in the morning. Injected 20 *c.c.* serum.

October 22. Temperature still very high, in spite of cold water enema; phenacetin seems to reduce it for a couple of degrees, but it so soon goes up after the effects of the drug have passed; pulse 90, and going downward; urine free, amount of albumin increased; vomiting still continues.

October 23. Temperature between 102 and 103 deg.; pulse from 80 to 90; jaundice well marked; headache and backache still present; vomiting at times—vomited matters consist of bile, mucus and nourishment given.

October 24. Temperature, A. M., 102 deg.; P. M., 103 deg.; pulse 90; vomiting continues; jaundice more marked; albumin in urine about the same.

October 25. Temperature went down to 100 deg. to-day; symptoms generally ameliorated, especially vomiting.

October 26, 27, 28 and 29. Temperature ranges from 101 to 102 deg.; pulse has fallen below 70; jaundice continues; urine free, amount of albumin diminished; patient improving.

October 30. Temperature normal; pulse 60; patient very weak, but greatly improved; vomiting ceased.

The patient went through a rather tedious convalescence, but was discharged thoroughly cured on November 14, 1899.

CASE 8.—Antoine Rizan, aged 25 years, born in France; in America four years; a milkman; has been sick seven days; admitted October 20; with high fever; intense congestion of upper part of body and eyes; albuminous urine 10½ per cent.; pain in the back and head. Injected immediately upon admission with 20 *c.c.* serum.

October 21. Condition same as the day before; vomiting.

October 22. Temperature somewhat lower; symptoms ameliorated; vomiting diminished; is able to retain liquid nourishment.

October 23. Condition improved, urine contains less albumin.

This case continued to improve on to the 25th, the fever left him. He was discharged cured, with normal urine, on November 3 or 4.

CASE 9.—Oscar Harst, admitted on October 21, in Charity Hospital with a typical case of yellow fever of moderate severity and of two days' duration. Temperature 103½ deg.; pulse 105; urine free from albumin and copious. Injected on 21st. 10 A. M., 20 *c.c.* Sanarelli's serum. 8 P. M. Temperature 104½ deg.; pulse 102; mind clear.

October 22, 8 A. M. Temperature 104, pulse 95; headache, backache; epigastric tenderness; nausea. 8 P. M., temperature 104⅕ deg., pulse 88; injected 20 *c.c.* Sanarelli; urine 29 oz., no albumin.

October 23, 8 A. M. Temperature 104 deg., pulse 105; vomiting; urine 34 oz., 3 per cent. albumin; symptoms as before. 8 P. M., temperature 103⅖ deg., pulse 80; still vomiting.

October 24, A. M. Temperature 103 deg., pulse 94; vomiting continuous. P. M., temperature 103 deg., pulse 88; no change in condition; gums soft; vomiting black; urine 24 oz.: 5 per cent. albumin.

October 25, A. M. Temperature 105 deg., pulse 90; symptoms as above. P. M., temperature 103⅘; pulse 88; urine 23 oz., 6 per cent. albumin; vomiting continuous; no brain symptoms.

October 26, A. M. Temperature 102 deg., pulse 90; patient still vomits, but only when nourished. P. M., temperature 101 deg., pulse 86; urine 31 oz., albumin 6 per cent.

October 27. Temperature 100⅗ deg., pulse 72; vomiting; otherwise improved; 28 oz. urine, 10 per cent. albumin.

October 28, 29 and 30.—Condition about the same; vomiting has stopped; urine more free, but still albuminous.

October 30.—Temperature normal; pulse, 68; symptoms ameliorated; thirty-two ounces of urine, 10 per cent. albumin.

The patient continued improving, but was weeks before he was able to leave the hospital.

Besides the above, there were two other hospital cases to which the serum was administered, but they were aggravated cases, late in the disease, with marked anemia and profuse hemorrhages; both of them died within forty-eight hours thereafter, without the least amelioration of any of their symptoms. The three following cases were treated in private practice:

CASE 10.—E. J., male, a native of Italy, aged 25; in New Orleans two years; on October 8 was taken with a severe chill, with headache and backache.

October 9 his temperature was 103 deg.; pulse, 108; intense congestion of face and eyes; headache and backache; urine free, non-albuminous.

October 10.—Temperature 104 deg.; pulse 100; epigastric tenderness, great prostration; intense headache; otherwise as day before; urine, a trace of albumin. Injected 20 *c.c.* Sanarelli's serum 6 P. M.

October 11.—Temperature 104½ deg,; pulse 100; vomiting, other symptoms as before; urine contains more albumin, is less free; a tendency to delirium.

October 12.—Temperature 104 deg.; pulse 96; vomiting more profuse, bile stain; urine diminished, albumin, slight jaundice apparent in conjunctiva.

October 13.—Temperature 103 deg.; pulse 90; vomiting rendered less and only when food is taken; urine still too scanty, 5 per cent. moist albumin; weak but mind clear.

October 14.—Temperature 101 deg.; pulse 72; patient better, vomiting at rare intervals; is able to take liquid nourishment in small quantity at times. Urine still albuminous but freer.

October 15 and 16.—Temperature 99 deg.; pulse 60; except on account of his intense weakness, patient would consider himself well; urine still albuminous, but more copious.

October 23.—Patient discharged, cured, no more albumin in urine.

CASES 11 AND 12 were two mild cases, but undoubtedly cases of yellow fever with never a very high temperature (102 3-5 maximum); only a trace of albumin; both were children, *aet.* 12 and 15 respectively; they were given 20 *c.c.* of serum each on the second day of the disease, but nothing showed that this has acted in any way to mitigate symptoms or shorten the course of this disease.

From the above cases, which limit our experience with the anti-amarylic serum of Sanarelli as a curative agent in the human being attacked with yellow fever, we are forced to conclude that this agent, in our hands, has shown no curative powers whatsoever. None of the important and dangerous symptoms of the disease having been in any way mitigated, or prevented, by its administration. Our hospital cases, it is true, were severe cases, and in some of them, treatment was begun at so late a date as to preclude all hope. However, we have had cases enough we believe, and the patient's symptoms before and after serum injection have shown so little change as to warrant our conclusion, as expressed above. In justice to Dr. Sanarelli, it must be said that he has never pronounced himself as believing absolutely that his serum was curative in the graver cases; he cautions all users of same, that the whole subject isstill under study and recommends that this serum be used early. This latter instruction is not always easy to follow as a diagnosis can not always be made early. Indeed in early cases of yellow fever, it is difficult to say which are going to be severe and which not, and judging by an experience in this city in the last two years, the great majority of cases are benign and get well under any treatment and necessarily serum employed at random in these cases would be at a great advantage.

As regards the immunizing property of the serum in the human species, we have no experience and can not speak with authority.

Experiments performed on smaller animals in our laboratory do not warrant us in entertaining a high regard for its immunizing power. In October we attempted two series of experiments on rabbits, as follows:

On October 5, rabbit No. 1, weight 1410 grammes, was injected intraveneously with 5 *c.c.* of a twenty-four-hour old bouillon culture, bacillus icteroides.

Rabbit No. 2, weight 1390 grammes, was injected with 5 *c.c.* twenty-four-hour bouillon icteroides, .25 *c.c.* serum.

Rabbit No. 3, weight 1370 grammes, was injected with 5 *c.c.* bouillon culture bacillus icteroides, and .5 *c. c.* serum.

Rabbit No. 4, weight 1800 grammes, was injected at 11 A. M. with .5 *c.c.* serum, and at 5 P. M. with 5 *c.c.* bouillon culture bacillus icteroides.

Rabbits Nos. 2 and 3 died October 7; Rabbit No. 1 died October 9, and Rabbit No. 4 died October 10. Autopsy in all cases showed great similarity of lesion, especially in Rabbits Nos. 1 and 4. Congested mesentery, with ecchymotic spots, fatty and friable liver, congested stomach with ecchymotic spots on mucous surfaces, fatty kidneys; bladder in Nos. 2 and 4 empty, in Nos. 1 and 3 contains urine, with albumin; spleen about normal; heart empty, muscular walls fatty. Cultures made of Nos. 1 and 4 and determined bacillus icteroides.

We repeated these experiments later in the month with slight, if any, variation.

Clinical Reports.

A CASE OF GUNSHOT INJURY OF THE SPINE.*

BY S. P. DELAUP, M. D., CLINICAL ASSISTANT TO THE CHAIR OF GENITO-URINARY AND RECTAL DISEASES, N. O. POLYCLINIC, NEW ORLEANS, LA.

The case reported in this paper was that of a male, 18 years of age, a plantation laborer, whose previous health had always been very good. The history was, that while on horseback he had been shot with a 32-caliber pistol by a man, likewise on horseback, who stood about twenty feet away from him. The shot had taken effect, and had made an entrance wound at the base of the neck about one inch above and one inch to the left of the left sterno-clavicular articulation. He fell to the ground at once, was carried home, and having recovered from the shock gave evidence of paralysis of the lower extremities. His mental state was good; in fact, his condition in general had not been aggravated by his fall from the horse. There had been a slight hemorrhage from the wound at the base of the neck, but otherwise it had caused him no trouble, and had healed completely within two weeks. About this time, his condition not having improved, he was sent to the Charity Hospital, and admitted on August 22, 1898, fifteen days after the date of the injury.

The paralysis of motion and sensation in the parts below the sixth rib was complete, and had come on instantaneously. There was also paralysis of the bladder and of the sphincter of the bowel. There can be no doubt that we had here to deal with a serious lesion of the cord. The sudden onset of these symptoms and the completeness of the paralysis, together with the total loss of the knee-jerks and other reflexes, were held as evidence of the fact that the lesion was not due to presence of effused blood nor to pressure of the bullet lodged in the spinal canal, but was a destructive one, involving probably a complete section of the cord. Notwithstanding that every care was taken to maintain the nutrition of the paralyzed parts, a bed-sore formed over the sacrum about the end of the first week and persisted as such throughout the remainder of the patient's life.

Other factors in the production of the bed-sores were the rapid emaciation and the constant leakage of urine, and latterly also of feces. The pulse and temperature were at first normal; when the bed-sores formed, there was febrile reaction, due no doubt to absorption of septic matter.

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*Read at the meeting of the Louisiana State Medical Society, May, 1899.

Urine was sometimes clear, sometimes clouded with mucus. It was drawn off at regular periods, but in the intervals part of it escaped involuntarily. The bladder was washed out with boracic acid solution at stated intervals.

To exactly locate the bullet an examination with Roentgen rays was decided upon, but owing to the fact that the apparatus was out of order at the time, a week was lost waiting. On examination with the patient seated, the bullet was distinctly located on the right side of the spine on a level with the spinous process of the third dorsal vertebra. A skiagraph was taken and another week wasted waiting for the developing of the skiagraph, which proved a failure. The patient was again examined with the X-rays, lying on his left side, and the findings of the first examination confirmed. Another fruitless attempt at skiagraphy was made. Considering the hopeless condition of the patient, the removal of the bullet was decided upon with the hope that probably the symptoms might be due to pressure of the bullet on the cord. The patient was properly prepared and the operation, laminectomy, performed September 25, 1898, forty-eight days after the inception of the injury. A linear incision from the spinous process of the first to the spine of the fifth vertebra was made, the soft parts detached and retracted, and the laminæ of the third and fourth vertebræ exposed. With chisel and hammer the laminæ were cut through and the cord well exposed to view. On opening the spinal canal, the membranes were found to be slightly adherent to the laminæ behind, and the bullet was found behind the lamina of the third vertebra, free and loose. The cord was completely severed, the two ends being fully an inch apart. The spinal wound healed kindly and would have closed by primary union, had it not become infected with pus from the sloughing bed-sores over the sacrum. The flexors of the lower limb became very much contracted, so that the patient lay curled up in the bed, and it was not possible to straighten out the limbs. The skin over them was extensively undermined. The patient gradually failed in strength and died seventy-two days after the reception of the bullet wound and twenty-four days after the operation.

In scanning the literature on this subject I have been forcibly impressed with the divergent and contrary opinions of the leading surgeons. Some advocate surgical interference, while others, just as noted, recommend an expectant treatment. Operative treatment of fracture of the spine, or ordinary injuries of the spine, is justly deprecated by all. Most operators, however, and among them some of the opponents of the operation of laminectomy in any case of simple fracture, view gunshot injuries from a different standpoint, and look with favor upon operation in gunshot wounds. Vincent (*Revue de Chirurgie*, August, 1893) says: Whatever be the nature of the injury to the cord, unless it be complicated by serious injury to the abdominal or thoracic viscera, and provided the gunshot wound has involved the posterior or lateral parts of the spine at an accessible region, the surgeon should open up the track of the bullet as far as the vertebral arch, and, after investigation of the nature and extent of the lesion, extract any foreign bodies likely to compress or irritate the cord. If it be necessary to trephine the walls of the spinal canal he should not hesitate to do so. Such treatment may be found beneficial, and, though sometimes useless, will never do any harm if practised under strict antiseptic precautions.

In my attempt to classify such injuries I was unable to improve upon the classification of Dr. T. J. Prewitt (*Annals of Surgery*, Vol. XXVIII, 1898). He divides gunshot injuries of the spine into three classes:

(1) Those that simply fracture the arches.

(2) Those that invade the canal, crushing the cord and damaging the vertebræ.

(3) Those that are complicated by serious injury to abdominal or thoracic viscera.

The first class is readily disposed of, as most progressive surgeons would advise immediate treatment by laying open the tract of the wound, clearing out fragments of bone, laminectomy if necessary, sterilizing the wound, draining and applying antiseptic dressings, observing the most rigid antiseptic precautions. Opinions vary as to the treatment of the second class of cases, those in which the bullet has invaded the canal, lacerated the cord and possibly buried itself in the vertebra. Some writers maintain that such cases are inevitably fatal, while others report remarkable recoveries.

It may be stated as a rule that patients with such lesions die within a year of the reception of the injury, though unique cases are reported in which after complete transverse lesion of the cord at various levels, the individuals survived for periods of twelve, fourteen, twenty-six years, or even longer. The two great determining causes of death where the patient survives the shock, etc., are, first, inflammation of the bladder, leading sooner or later to surgical kidney; and, second, bed-sores from wasting and trophic failure, followed by septicemia and exhaustion. The factor which most largely determines the rate of mortality is the proximity of the cord lesion to the brain. Any complete transverse lesion of the cord in the cervical region is almost certainly fatal within a few days; if above the origin of the phrenic, death is, of course, instantaneous. In military practice the mortality from such wounds is enormous and undoubtedly due to shock, hemorrhage and septic processes. The records of 642 cases of gunshot injuries of vertebræ reported in the Medical History of the Civil War show beyond doubt that the prognosis is progressively more favorable as the injury recedes from the medulla. This number, of course, does not include those who fell during action with such injuries and perished in the field without treatment. Records show that of that number (642) 55 per cent. proved fatal. We would infer by this low mortality that cases of injury not involving the spinal cord were included. Of those who died 70 per cent. were injured in the cervical, 63 per cent. in the dorsal and 45 per cent. in the lumbar region.

In civil practice the bulk of such injuries are caused, as in the case related above, by small arms bullets.

That death does not necessarily follow a division of the spinal cord is demonstrated by numerous cases reported by Eve (*Am. J. of the Med. Sciences*, Vol. LVI, 1868).

According to Prewitt's tabulation there have been reported since the aseptic era forty-nine cases of gunshot injury of the spine, twenty-four of which were subjected to operation, with eleven recoveries. Twenty-five were not operated upon, with eight recoveries and seventeen deaths. These statistics show a decided preponderance in favor of operation.

In conclusion I may best summarize the opinion of the best operators by stating that it is the duty of the surgeon to advise immediate operation in all cases of gunshot wound of the spine, provided they are operable and free from contra-indications to operation.

TRANSPOSITION OF THE VISCERA—REPORT OF A CASE.*

By L. G. Le Beuf, M. D., New Orleans.

Wallace Perkins, aged 31 years, white, male, native of Lafourche, Louisiana; weighs 75 pounds; 4 feet 10 inches in height; thin, emaciated.

Subjective Symptoms.—He has fever at times, coughs considerably, suffers with short breath, specially at nights; expectorates considerably.

Objective Symptoms.—Dullness over both apices of lungs, increased vocal fremitus, subcrepitant râles on left side of apex; when admitted into hospital, sputum being examined contained bacilli tuberculosis. Further physical examination revealed apex beat of heart three-fourths of an inch below the right nipple, one-half to the left toward the ensiform cartilage.

Percussion and auscultation show plainly the heart lying transversely beneath the sternum and to the right, with the aortic valves heard plainest in the third intercostal interspace on the left side and the initial valve at the apex below the right nipple. The line of dullness also proves this.

On the left side, starting between the sixth and seventh ribs, there is also a marked dullness, the flat typical liver percussion note which extends a little beyond the edge of the costal arch. On the right side there is also a slight dullness beneath the tenth rib, about on a line midway between the mammary and axillary lines, probably the spleen's dullness.

Just below the heart, on the right side, percussion reveals typical, loud tympanitic resonance of stomach, which is made more evident by letting patient swallow some water; keeping the stethoscope over this region you can hear the loud gurgling noise made there by the entrance of the liquid in the organ.

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* Reported at the Orleans Parish Medical Society, June 24, 1899.

A CASE OF VISCERAL TRANSPOSITION, AUTOPSY WITH PHOTOGRAPH.*

BY J. LAZARD, M. D., NEW ORLEANS.

This interesting case was admitted to ward 38, of the Charity Hospital; and with permission of the House Surgeon, I will report same.

Ward history: Sallie Young, age 24, colored; was admitted November 16, 1894; breathing at this time was rapid; pulse full and bounding; some temperature. *The left lung was found to be flat at the base.* This sign, together with the rapid respiration and cough, made the diagnosis of pneumonia. She became comatose and died on November 17, 1894.

Post mortem: External appearance robust. Heart on right side; slight pericarditis, aortic valves degenerated. Lungs transposed, some slight pleuritis, otherwise normal. Spleen transposed and congested. Liver transposed and enlarged. Stomach and pancreas transposed. Sigmoid flexure on the right side; cecum on the left side. Kidneys congested. Some pus in the left kidney.

Cause of death: congestion of kidney with left pyonephrosis.

For such an important case these notes are somewhat meagre, but I am in no way responsible, as I was not present at the autopsy.

This case is interesting for many features. J. Cloquet (*Nouveau Dictionaire*, Paris, 1826, p. 573) has met with this condition three times in ten thousand autopsies. E. Littre and Ch. Robin (*Dictionaire de Médecine*, Paris, 1865) say that this form of transposition has been seen only in man. Dr. E. A. White, a prominent veterinarian of this city, informs me that while he was a student of the University of Pennsylvania he dissected a cow that had its heart in the neck, the other organs were normal. Literature is plentiful with the report of individual cases.

From the photograph will be seen that the heart is between the third and fifth interespaces on the right side. The left has three lobes, the right two. The esophagus is inserted into the stomach from the right side. From the position of the liver (left side) a diagnosis of pneumonia was made giving rise to physical signs above noted (it is very plain that the examiner

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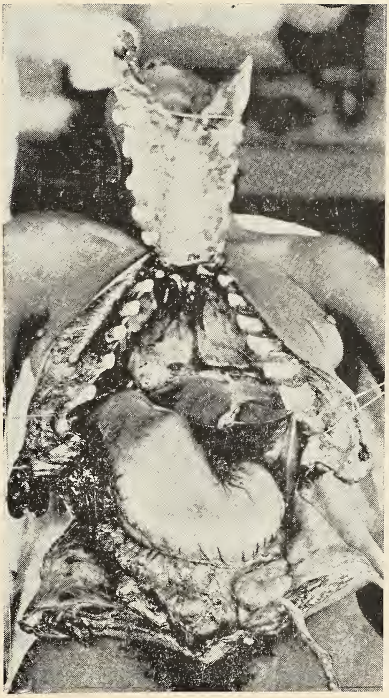
*Also reported at Orleans Parish Medical Society, June 24, 1899.



Dr. Lazard's Case of Transposition of Viscera.

mistook the dullness of the liver for dullness of the lung). The cecum is on the left side, and the appendix will be seen drawn from the abdominal cavity and placed on the left thigh. Sigmoid flexure is on the right side.

Society Proceedings.

ORLEANS PARISH MEDICAL SOCIETY MEETING, JUNE 24, 1899.

Dr. Le Beuf related a case of *transposition of viscera* (see page 91). The man was quite a curiosity, but was lost to observation because too many came to see and examine him. All the organs were transposed as is the case with instances reported. This was the first case the doctor had seen.

Dr. Lazard reported a case of the same nature in a woman and had looked up the literature with reference to this class of cases (see page 92).

Dr. von Seydewitz stated that the general opinion has been that only man has transposition of viscera, but he remembered a woman on constant exhibition at the Vienna clinic. The doctor stated that the manager of the Chalmette laundry has complete transposition.

Dr Lazard stated that in looking up the literature he had found frequent reference to the transposition of the colon, but complete transposition was unusual.

Dr. Le Beuf related a *case of a woman* whom he had *delivered of a child with amputation of the big toe and with further amputation obliquely across the foot of the third and fourth toes.* In his opinion this was probably an amniotic amputation. He referred to these cases as responsible for the superstition of maternal impressions.

Dr. Dyer asked if there was a cicatrix at the point of amputation.

Dr. Le Beuf said not of the big toe, but in the oblique amputation.

Dr. Gessner asked if the doctor had examined the amniotic sac for bands.

Dr. Le Beuf answered that he had washed out the sac but found no detritus. The amnion was immense. There was a large band and roughness at the placenta.

Dr. Miller, with regard to the amniotic fluid, was it more or less than usual?

Dr. Le Beuf. A great deal more than usual. It came after the child.

Dr. Miller. This presence of amniotic fluid is put down as a cause of such amputation, but in most cases the absence of fluid causes it. At one time the deformity was believed to be due to gangrene of the missing member. Some parts of amputated members have been found. The lack of development is probably accountable rather than the amputation.

Dr. Le Beuf. The obliqueness of the cut would rather argue against such lack of development.

Dr. Miller referred to a case of a woman with uterine fibroids, whom he had delivered recently. The right hand only presented four fingers, the thumb being absent, and was attached directly to the arm. The forearm was entirely missing. The left hand had four well-marked fingers, a rudimentary thumb, and was attached to a forearm one-half the length of the normal forearm at birth. A large nevus was found on the forehead and right parietal bone. The child died about sixteen months later of enteritis. In this case the possible exciting cause was the presence of several small subperitoneal and interstitial fibroids in the uterus of the mother. The presence of these growths caused irregular contractions of the uterus after the birth of the child and gave rise to rather annoying hemorrhage. Such cases are not amputations where the member has been partially reproduced but simply instances of arrested development in the latter half of the second month of intra-uterine life.

Dr. Le Beuf said that his case was anomalous, as the delivery was seven weeks over time.

Dr. Dabney related *a case of a steady tippler* who had sent for him to relieve a bilious colic. The patient was much jaundiced; he was weak in his legs; his left arm grew weak. The extremities of left hand were paralyzed. In two weeks time there was paralysis in both arms and hands. A typical alcoholic paralysis. The doctor decided that rest, quiet and strychnin were indicated, but not the use of a battery or application of electricity. He gave one grain of ipecac every three hours in order to let him get rid of his whiskey. The doctor is satisfied that thirty days more will see him well. Dr. James Jackson, in America, in 1822, dissociated these cases from lead paralysis. Chaumel, in 1828, called attention to an "epidemic" of these cases. He, with Jackson, had differentiated these from spinal cases.

Dr. Miller asked what Dr. Dabney thought was the condition of the nerves in this case.

Dr. Dabney believed that irritation was usually responsible that there was no degeneration of the nerves, but that the paralysis was due to some toxin element produced by the alcohol.

ORLEANS PARISH MEDICAL SOCIETY, MEETING JULY 8, 1899.

Dr. Dyer read a paper on *linear nevus*, demonstrating the several varieties with a series of photographs, chromo lithographs and engravings showing the differentiation of this condition from herpes zoster, lymphangioma circumscriptum, but also showing the similarity in pathologic process in cases of these conditions.

The term nevus is defined as a natural mark or blemish, a circumscribed deposit of pigmentary matter in the skin. It is usually and justly, from the etymology of the term, considered congenital.

Strictly speaking, it is not so, for by far the larger number of nevuses occur some time after birth.

Among the varieties of nevus, there is a large range of types, some being simple pigment marks, others assuming fantastic shapes, so as to suggest the outlines of fruits, small animals and the like.

The more noticeable nevuses are usually vascular in structure, and they vary from simple hypertrophy of superficial blood vessels up to deep seated varices of either veins or arteries.

The particular type of nevus presented is one of peculiar distribution, arrangement and with unusual characteristics.

The term *linear nevus* has been given by Morrow*, of New

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* New York Medical Journal, January 1, 1898.

York, to a class of eruption having its groups of lesions distributed apparently along one of the nerve trunks or branches. His nomenclature is particularly fortunate in the light of the fact that this eruption always follows definite lines in its distribution, these lines being determined either by the cleavage of the skin or else by the distribution of the cutaneous branches of some one or more sets of nerves.

Various observers have given different names to this eruption, the commonest term used being *nevus unius lateris*, or unilateral nevus, because of the proverbial limitation of the eruption to one-half of the body. I have been fortunate enough to correct this term in having observed several cases of bilateral linear nevus, thus making the definite use of the rerm "*unius* lateris" impossible.

Linear nevus has certain defined characteristics which distinguish it from all other varieties of nevus and from other eruptions.

It almost always occurs along the axis of a limb or extremity, or else it follows the lines above mentioned transversely across the trunk or in festoons following the nerve distribution. Hitherto, linear nevus has been called "papillary" or "verrucose" because most cases observed present warty cells. That this is not always so will be seen from the cases which I report.

The resemblance of the eruption at first glance to herpes zoster indicates a probable neurotic origin, which in many instances can be determined.

I have arranged a series of photographs, engravings and chromolithographs to show you the variety of lesions possible as a result of a neurotic impression on the child.

You will notice that the simplest type presented as an instance has a distribution of pigment strongly suggesting a neurotic influence, although the lesions are simple macules.

In another of the photographs you will see both pigment in macules and in distinct papillary growths.

In another the warty tendency is very marked as is also the tendency to trophic change.

The grouping of lesions present show the close relationship between the several structures of the skin, all of them together indicating the possibility of alterative change from the pigment element, the keratin cells, the lymph and blood vessels and even in the nerves and glands of the skin. The cases of bilateral nevus are exceptionally interesting because of several points at variance with the ordinary unilateral type, and these I wish especially to report in detail:

The first case, a boy of eight, showed an eruption of warty type located on the face, shoulders, chest and back; distributed symmetrically, beginning at the outer half of each orbit and extending over ears, along neck, over shoulders, in axillae, then spreading anteriorly and posteriorly, showing over the chest on the outer side, and over the scapular region, there joining with a band from the neck and, paralelling a like eruption from the other side, extending along the spinal column as far down as the sacrum, where the eruption ended in a spray of lesions.

The second case was in a girl of seventeen, presenting lesions on the face, limited to chin, nose, alae nasi and slightly on the cheeks, just outside the alae nasi.

The eruption was bilateral and symmetrical.

The lesions were grouped in clusters, each lesion distinct. These were small tumors, varicose mostly, others forming little pedunculated masses; the latter pin-head sized, the former more or less flat and sessile—some flat and elevated. The lesions were erectile, especially vascular and engorged under excitement and in hot weather, but always marked at menstrual period.

The third case was an infant of 21 months. The eruption was purely pigmentary, extending from the clavicle on either side in front, and spreading downward and outward in a curve, which finally formed almost a semicircle, extending from the last dorsal vertebra to the upper border of the first rib at its juncture with the sternum. The whole area embraced was covered with blotches of pigment deposit, varying from pale buff to a chocolate brown, the borders being the more deeply colored.

Dr. Miller reported *A case of fatal uterine hemorrhage complicating puerperal sepsis.*

A well-developed colored woman, 28 years of age, was brought to the Charity Hospital June 22, in an exhausted state, having been in labor for three days and unable to deliver herself. She gave a history of difficult labor in two preceding pregnancies, and was treated in the Charity Hospital for puerperal fever after the last child. At the time of admission labor pains had ceased entirely; she had a temperature of 101 deg. F., pulse 124, was complaining of rigors and chilly sensations, and profoundly shocked. Examination revealed a foot and leg of the child protruding from the vagina, which was almost in a state of decomposition, and accompanied by a very offensive vaginal discharge.

Under chloroform anesthesia Dr. Bloom readily delivered the child and placenta, and owing to the septic condition an antiseptic douche was given. The uterus was then cleansed with hydrogen peroxide and snugly packed with gauze. At the time she was placed in the ward her temperature was 99 deg. F., the pulse rate 124 and respiration 30. Stimulation with strychnia sulphate and tincture of digitalis was commenced and repeated every three hours. In addition to these stimulants, milk punches, Ducro's elixir, beef tea and nutritive enemata were given at regular intervals. The temperature did not exceed 102 deg. during the first day (June 22), and the pulse rate did not vary much above or below 130 per minute; but during the second day the temperature at one time reached 104 and had to be controlled by frequent cold sponging of the body.

The gauze packing in the uterus was removed twenty-eight hours after its insertion, and the uterus was thoroughly irrigated with four gallons of 1 per cent. formalin solution. Immediately after the irrigation 20 *c.c.* of anti-streptococcic serum were administered hypodermically. An occasional small dose of phenacetin was administered when the temperature reached 102½ deg., and cold sponging was resorted to when indicated. The anti-streptococcic serum had no appreciable effect.

On June 24 the anti-streptococcic serum was repeated, and during the day the uterus was irrigated twice with 1 to 1000 formalin and normal salt solution. The temperature ranged from 99.6 to 105 deg. on June 25, and three intra uterine douches were given. A douche of bichloride 1 to 5000 was given at 1:30 P. M., and after that time the fever slightly declined. At 4:30 P. M. of the 25th a sudden and profuse uterine hemorrhage developed, which almost ended fatally and necessitated packing the uterus with gauze and the intravenous administration of a half gallon of saline solution. The pulse rate, at the time the saline infusion was administered, was 170 per minute. The woman rallied poorly, the temperature ranged from 102 to 103.8 and the pulse remained about 140 per minute until the morning of the 26th (sixteen hours after the first hemorrhage), when hemorrhage suddenly developed the second time. Ergot and stimulants were given, but owing to her profoundly depressed condition, she died in a few minutes. This last hemorrhage occurred while the uterus was packed full of gauze. As the case presented some points of interest, a *post mortem* was requested and Dr. Pothier, pathologist of the Charity Hospital, held one four hours after the patient died. The only internal organs which showed pathologic changes were the liver, kidneys and the uterus. A state of fatty degeneration was marked in both the liver and kidneys. The uterus was enlarged and an area of soft necrotic tissue was found in the lower left quadrant, just above the internal os. It was from this necrotic slough that the hemorrhage occurred which caused the patient's death. I understand that the other parts of the uterine cavity showed no degenerative changes, so it must be inferred that the temperature and all the accompanying symptoms were caused by this small localized area and not to an infection at the placental site or in some cervical or vaginal tear. The cause of this localized necrotic area is evident. The woman had been in labor for three days without having the services of a physician, and the bony walls of the pelvis were pressed firmly against the uterine walls for this long period at the place where the sloughing occurred.

The pathologist's report is as follows: Body of colored female, well nourished, conjunctiva yellow, pupils slightly dilated, muscular rigidity marked, a normal heart, the left lung was normal, the right bound down by old adhesions, spleen enlarged and congested, liver showed marked fatty degeneration, gall bladder full, normal pancreas, kidneys showed marked fatty degeneration, the uterus was enlarged about the size of five months' gestation, and presented an area of soft necrotic tissue on lower left quadrant just above internal os.

The *post mortem* finding in this case naturally suggests the surgical treatment of such conditions, especially the indications for the operation of hysterectomy which has been discussed quite exhaustively during the past six years. The condition was distinctly circumscribed and limited to tissues which could have been removed very readily, and it is possible that if a radical operation had been done before the woman was exhausted by hemorrhage her life might have been saved. But however clear the indications for operation seemed, viewing them from a *post mortem* standpoint, the case shows to a marked degree the difficulties of discriminating between cases that should be promptly operated upon and those that should as promptly be treated by simple douching and in exceptional cases curetting. The indications for radical surgery are as marked in some instances of puerperal sepsis as in a gangrenous limb, but it is in the questionable cases where the surgeon is called upon to decide whether a case is one of puerperal intoxication or true puerperal infection that the mistake is likely to be made. This has formed the chief and just objection to the operation of hysterectomy. Any operation upon the lying-in woman is repulsive, in a manner, to the surgeon, and such operations will never become popular or have a general application for the reason they will never be elective operations.

The question of early hysterectomy will have been settled when the surgeon is able to differentiate clearly between puerperal intoxication and true puerperal infection. He must be able at the same time to recognize the steps by which a virulent intoxication might set up pus centres in the uterine tissues or surroundings also. The pathology of true puerperal infection is well established as a septic inflammation of the cervix, the uterine muscle or the endometrium; it may be primarily a septic endometritis, originating in lacerated cervix, which infects secondarily the fallopian tubes, and in some instances even the ovaries. The lymphatic system is constantly involved in this form of infection, especially the glands in the connective tissue about the cervix. One may often reach a conclusion as to the presence of this form of infection by examining the vault of the vagina, where enlarged glands will be located, which may be mistaken for diseased tubes and ovaries, such cases often terminate in the classic extra peritoneal abscess of the pelvis, and drain into the vagina or rectum, or over Poupart's ligament.

These cases often end in pus collections in the broad ligaments and can be opened by vaginal incision. Far oftener, however, they terminate in pus collections in the tubes and on the surface of the uterus just beneath the peritoneal covering.

Such cases can be fairly diagnosticated. It is in instances of the acute stormy types before the fallopian tubes are indurated or even painful areas develop that we wish some guiding principle. A. M. Carteledge*, an eminently practical surgeon, has proposed about as clear a working basis as can be established. "If the uterus has been cleansed by irrigation and probably curetted and properly drained with tubular drainage; in other words, if the infected tract has been repeatedly and rigidly treated as we would an infected amputation stump and the symptoms do not yield in three days we may suspect extension to structures which can not be reached by such measures." He does not claim that radical surgery is to be instituted immediately, however, for he very correctly admits that even when the septic infection has extended to the deeper structures, the conditions may prove amenable to less radical measures than hysterectomy.

Hirst very truly sums up the matter in a manner acceptable, both to the physician and the surgeon:

"First and foremost, then, the attendant should avoid the operative treatment of puerperal sepsis if possible, and should not seek an excuse for surgical intervention merely in the cardinal symptoms of septic infection, high temperature, rapid pulse and general depression. He should demand some tangible evidence of those forms of sepsis that are amenable to surgical treatment. But the physician of to-day, while reluctant to operate upon a patient under the least favorable circumstances, and on his guard against unnecessary or harmful surgery, must be prepared, in the event of certain symptoms or complications, to operate with the least possible delay. Thus, on the first appearance of symptoms that will justify a diagnosis of suppurative peritonitis, the abdomen must be opened without a moment more delay than is necessary for an aseptic operation. Again, in the presence of exudate, adhesions, or unnatural enlargement of any pelvic structure, suppuration may be suspected if the physical signs do not improve, and if the temperature, pulse and general condition indicate a condition of septic inflammation. It is hardly necessary to state that if pus forms it must be reached and evacuated irrespective of its situation. Just how long to wait, however, is a question requiring experience, good judgment and a special study of each individual case for its correct answer."†

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* Tansactions Southern Surgical and Glynecological Association, 1895.
† Hirst, Text-Book on Obstetrics.

Dr. Martin said that Dr. Miller had presented the question of hysterectomy in these cases more clearly than he had ever heard it put. The operation, to his mind, was not indicated unless there was pus formation. The mortality is large in this condition, but in neglected cases. The doctor recalled seven cases at the New Orleans Sanitarium, in none of which was the temperature below 104 deg. at time of admission. Only one of these cases died, and all were treated by uterine douches. When operation is indicated, the modified method is usually sufficient. It is bad judgment to operate when symptoms are acute.

Dr. Dabney said it was in this class of cases that we were expected to obtain so much from the anti-streptococcic serum. The *Therapeutic Gazette* for June had an article, apparently inspired by Parke, Davis & Co. themselves, in which the opinion was expressed that, in the hands of the manufacturers, experiment and review of its use had shown the anti-streptococcic serum eminently unsatisfactory in such a class of cases.

Dr. Lazard said that while interne, in Ward 36, at Charity Hospital, three negro cases died. In these anti-streptococcic serum was used. He did not know, however, whether the infection was streptococcic or staphylococcic.

Dr. Gessner—In a case of bad knee joint, in Ward 1, pathologist reported the presence of staphylococci. Several injections of the anti-streptococcic serum had improved the boy, who is getting well. Some doubt existed in his mind as to the efficacy of the serum, as the boy improved rapidly after serum was stopped; more than this, irrigation and asepsis had been maintained throughout. Maybe the action of the serum was delayed. The doctor was inclined to think of the line he had read, "When we want to study trees, we do not study forests," as applying to the study of micro-organisms. There may be close relationship between all of them, and that may account for the response to conditions not exactly fitted to some.

Drs. Le Beuf, Barnett, Storck and Lazard spoke of having obtained varying effects in using the serum in tuberculosis.

Dr. Dabney suggested that the specimen used should be considered in estimating the result.

Dr. Le Beuf asked Dr. Miller, what had been the diagnostic points in his case, outside of the hemorrhage?

Dr. Gessner asked if the speculum had any usefulness, and said that the cylinder speculum in esophageal examinations had been found useful.

Dr. Miller reviewed the history of operative interference in these cases, referred to the danger of peritoneal abscesses; especially in the occurrence around the uterus; he referred to the investigation of the Southern Surgical and Gynecological Association, and their report upon the anti streptococcic serum, as having done no good, also that their investigations discouraged curetting. He said that the variety of puerperal infection must be known before the usefulness of the serum can be known. Instances of diphtheria and coli communis infection are mentioned as responsible. As to the diagnostic points: If you could know where the infection begins, the treatment would be easy.

Dr. Bruns related two interesting cases of practical interest. The first case, a man of thirty years, a robust laborer, had applied for treatment at the Eye, Ear, Nose and Throat Hospital. He presented *a large tumor, displacing the right eye downward and outward.* The patient was so young and so robust, and the growth so rapid, that he could hardly believe it malignant. He gave the patient the benefit of the doubt, and put him on his customary treatment for syphilis, occurring in this region: One drachm of tincture of belladonna ʒi, mercurial ointment ℥i was rubbed in daily in the forehead, and a bandage applied over the forehead after the rubbing. In addition potassium iodide was administered in increasing doses. This was kept up for one month, at the end of which time the tumor had been observed to have increased in size steadily and rapidly. An operation was indicated. He cut down to see what the tumor was, having obtained the permission of the man to remove the eye if it became necessary—a precaution he always observed. Did usual operation, and was surprised to find the tumor to be an *exostosis*, the larger part being the outer part. All around the orbit there were smaller exostoses, narrowing the orbital cavity and pushing the eye out. The eye was removed and the orbital contents partly evacuated. The tumor was found to be sessile, the apex dull. The danger of cracking the orbital plate precluded the removal of the growth. A pressure bandage was applied, and the tumor was left undisturbed. The wound healed nicely, but the tumor continues to grow. There is still some edema of the conjunctiva.

The second case was in a middle-aged (about forty-five years) thin, delicate negro woman. The *tumor in this case pressed the eye downward.* It felt like the small end of an egg. Its growth had been rapid, and the indication was that it was malignant. Operation was considered necessary, and indicated promptly.

The doctor pursued same plan as in other case—namely, the inunctions in the forehead and the increasing doses of iodide. At the end of three weeks there was no tumor perceptible. The cases show the difficulty which must arise in deciding the diagnosis and judgment in procedure. The tumor was just as hard as in first instance and similar in many particulars. The conditions, everything considered, should have been reversed, as it was far more likely that the young man should have had the syphilitic tumor than the colored woman.

He was reminded by the cases of an anecdote of Dr. P. Archinard: An old practitioner, who was not very famous for his brightness in sense, had been quite successful in obscure cases, which had gone the rounds from doctor to doctor.

When he was retired from practice, one of his fellow-practitioners asked him what plan he pursued in such cases to have acquired such success. He replied: "I treat everybody for syphilis."

Dr. Dabney remarked the value of Dr. Bruns' cases as emphasizing the necessity of using radical measures of mercurial medication in suspected syphilis. He said that he had read recently of some lawsuits, in which negligence had been preferred as a charge in cases where the inunction, intravenous or subcutaneous method of treatment had not been employed. He remembered the remarks of a professor at the University of Virginia, who said that negroes could be divided into three classes: "Those who had had syphilis, those who had syphilis and those who were going to have syphilis."

Dr. Martin called attention to an article he had read in the New York *Medical Journal* giving a practical *procedure for the prevention of fissured nipples.* Briefly it consisted in rubbing lanolin into the nipples at night and thoroughly washing them in the morning with soap (preferably white soap). He had now used this treatment successfully in five cases. He began this procedure about six weeks before expected labor.

Dr. von Seydewitz said that this treatment had been used in

Germany for over a year. He had mentioned it in a paper he had presented at the State Medical Society meeting this year.

DR. CHAVIGNY reported an interesting case of *vicarious menstruation* in a young colored girl who has never menstruated normally. She was twenty-two years old. Patient copulated for the first time at the age of thirteen years eight months. Four months after she became pregnant and was duly delivered of a nine months normal child which survived six months.

She did not menstruate previous to copulation, but only began to suffer from severe head and back aches and copious bleeding from the nose three months after she had become pregnant.

From this time on she would be taken monthly with severe head and back aches, which would necessitate her going to bed.

Pains would come on regularly twenty-four hours before she would have a copious hemorrhage from the nose, lasting about one hour, and resulting in the loss of about six ounces of blood. This would relieve all pains, and she would then be able to resume her daily work. About two years ago she again became pregnant, and was delivered at full term of a strong, healthy babe. The baby is at present nursing, and is in the best of health, and very well developed.

Throughout her second pregnancy and lactation this phenomenon persisted. Condition of patient when first seen was very good. She came to the hospital to know whether her menses could be brought on, and she was not suffering otherwise. Examination of the pelvic organs showed uterus to be of normal size and in proper position. The same can be said of the ovaries and tubes.

No sensitiveness of pelvic organs existed. She was put on one grain dose of potassium permanganate three times daily. The points of most interest are that, although she copulated when 13 years, 7 months old, the physiologic desire was not present and did not develop until three months after first pregnancy; that is, three months after conception.

She became pregnant before this vicarious condition had existed, and it was three months after conception when it first took place. This vicarious menstruation has persisted, even during her second pregnancy, and also during the period of lactation. She has never had any sanguineous discharge from uterus.

Dr. Hamilton Jones related the case of a *young negro girl of 17, who had, up to four years ago, never menstruated.* At the time of periods, however, her lips would swell very much. The girl had an immense goitre, for which thyroid extract was given. After some time, the menstruation began and the swelling of the lips ceased.

Dr. Graner related the case of a patient of his who had complete and *normal menstruation up to the seventh month of pregnancy.* She is now past the eighth month, and menstruated at last period, but not so freely as hitherto. The fetal heart is easily audible. The case is a *primipara.*

Dr. Walet reported a *case of cephalo-meningocele in a stillborn child of a primipara.* Four days ago he was called to patient, healthy and having had no disturbance during pregnancy. Found os nearly fully dilated, head presenting and around it a bulging membrane. He gave an enema and went home for his obstetric bag. On return in a few minutes found something still bulging, semi-fluctuant; took it then to be a placenta previa. There was no fetal heart sound; after ten minutes found head less perceptible; the mass was now found pedunculated. He traced it and discovered that it was attached to the skull, probably a meningocele. The labor was quite slow, but the child was delivered without forceps. The tumor was six inches in diameter, the pedicle three-quarters of an inch thick and quite round. The tumor was ruptured in several places. Some brain substance was found in the tumor, determining the correct diagnosis of a cephalo-meningocele. The woman has done well and has had no rise of temperature.

The question of our hospital methods in New Orleans was discussed and the impositions practised upon the visiting staff related. The fact that 20,000 cases were treated at the Charity Hospital alone last year, one-fifteenth of the entire population of New Orleans, was instanced as a strong reason why the profession should do something in self-protection. Dr. Dyer, the president announced that the matter would be referred to the Committee on State Legislation for consideration, with instructions to report at the next meeting.

N. O. Medical and Surgical Journal.

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS.

By a supreme effort, and after many years of attempt, the medical profession successfully occasioned the creation of a State law providing for a Board of Medical Examiners, with explicit powers and with explicit functions. That board has been in existence now for five years. To what end?

After an excellent organization, fraught with all sorts and kinds of promises, that board buckled on its armor and started out with every semblance of fulfilling the purposes of its origin. Meantime the profession of the State of Louisiana have waited patiently, and in silence, for the evidences of that sally.

What have been the results?

Annually, sometimes semi-annually, the board has excused its existence by holding examinations for candidates for the license to practice medicine. It made one bold essay, with successful issue, at an itinerant and ignorant quack, one Schrader. It succeeded, after months of sluggish legal tactics, in temporarily suspending the practice of one Fowler, in Algiers, who has only half yielded to the judiciary decision. Meantime, and since then, the champions appointed have rested on their laurels, and have supinely looked askance at the infringements of most of the sections of the law which gave them existence and position.

It was bad enough that the daily newspapers flounted the advertisements of flagrant quacks and the windows of most drugstores vaunted open violation of the law; but latterly the board has allowed itself, and with it the medical profession of Louisiana, to be grossly besmirched in the public press by a hoodlumistic quack, using a none too unwilling press, in its advertising columns, to assail and abuse for his own advantage the New Orleans profession especially.

Elsewhere similar laws are enforced and creditably. If the law is not invoked, it naturally cannot prevail.

In voicing what we believe to be the sentiment of the best of the profession in Louisiana, we feel that it should be no longer an appeal, but a demand upon the State Medical Examining Board to do its duty. That duty is plain; the law is clear.

We know how hard organization among medical men is now and how slow they are in action, but soon the question among them will be to what end has our State Medical Examining Board brought us? Inaction means either neglect of the purpose of that board, or sheer inability to exercise the instrument of the law at their command. We do not believe that the board is a sleeping beauty waiting for the prince of good fortune to wake them, and we believe that such remonstrances as we have uttered must avail.

USE OF SANARELLI'S SERUM IN THE UNITED STATES.

The *New York Herald*, in its issue of July 9, makes a positivistic statement to the effect that one Lockey, a yellow fever subject in New York, "*is the first human being in this country to be treated with the remedy which has come into use through the experiments of Drs. Sanarelli and Doty.*" Dr. P. E. Archinard's article in this number of the JOURNAL will correct that misapprehension.

We do not wish to detract from the credit which may be due Dr. Doty for his work in New York, but we must feel some degree of interest in establishing a priority which ought to have established itself.

With proverbial newspaper inaccuracy, the *Herald* has very likely presumed in its assertion, as we are not willing to believe that Dr. Doty has inspired such a statement without first informing himself. The seeking after the sensational by the lay press often carries into print work, half distorted, of medical men.

Dr. Archinard's experiments are interesting as showing a series of cases, mild and severe, in which the Sanarelli serum has, to his mind, proved of little value. Those cases which recovered, while the serum was used, were of such character as to negative any claim for the serum, as they would probably have recovered anyway. Of the twelve cases related four died, eight recovered; of these, two were not at all affected by the serum, and in the remaining cases the results were by no means conclusive. The experiments instanced, in which animals were inoculated, show a result far from predicatory of usefulness of the Sanarelli serum as at present constituted.

Medical News Items.

THE NEW YORK MEDICO-LEGAL SOCIETY has arranged an investigation of Christian science. Two lawyers, two physicians and two of the "cult" are to meet and discuss the claims of Christian science.

The announcement of this proposed step was made at the time a mass-meeting of intelligent men and women was held in New York, called for the purpose of protesting against the laxity with which the local courts had handled recent cases of death at the hands of Christian scientists. In Chicago recently two cases of diphtheria died under the auspices of the "cult."

DR. LAWSON TAIT'S REMAINS WERE CREMATED in accordance with his own wish.

CREMATION IN GREAT BRITAIN SEEMS TO BE GAINING GROUND, according to the statement of Sir Henry Thompson. Quoting him, the *Medical Record* states that in Woking alone the number of cremations increased from ten in 1886 to two hundred and forty in 1898; the cost for cremation raises from $50 to $75. Other towns in England are projecting crematories.

A CANCER SOCIETY has been started in London with the object of increasing knowledge of this condition, establishing a special library and to urge governmental inquiry.—*Medical Record.*

THE AMERICAN MEDICAL QUARTERLY has made its appearance very attractively. The first number, for June, is made up of several short articles, and others more elaborate. The illustrations are unusually well done. The *Quarterly* is well edited, and it is a regret that the name of the editor does not appear.

AT THE FIRST ANNUAL COMMENCEMENT OF CORNELL MEDICAL DEPARTMENT in New York there were fifty-eight graduates, twelve women.

TWO CASES OF LEPROSY, in St. John's parish, one trophic, one tubercular type, were committed in June to the Leper Home by Judge Rost. The cases were reported by Dr. N. J. Simon, the health officer of the parish, at whose instance the judiciary was made to act. The whole procedure is commendable, in that it has been impossible in New Orleans to get the judges to act in cases where every effort has been made.

RUSSIA HAS 5000 LEPERS so far enumerated.

CHARBON HAS DONE MUCH DAMAGE TO THE CATTLE AND STOCK in Louisiana during the past three months. Recently two cases in men were received at the Charity Hospital.

THE THIRTEENTH INTERNATIONAL MEDICAL CONGRESS will meet in Paris, August 2 to 9, 1900.

THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION will hold its ninth annual meeting at Washington, D. C., September 19, 20, 21, 1899.

Willards Hotel has been chosen for the headquarters, and special rates have been made for all interested in this meeting.

Many able papers have been promised, and a very successful scientific meeting is assured. There will be a large and varied exhibition of electro-therapeutic apparatus during the meeting of the association.

DR. WALTER DUSON, well known in New Orleans, has located in Asheville, N. C.

DR. H. L. SIMPSON has been re-elected City Physician of Pensacola, Fla.

SAVANNAH'S NEW HEALTH OFFICER.—Dr. W. F. Brunner, chief of the United States Marine Hospital staff at Havana, has accepted the position of health officer of this city. He is recognized as one of the leading sanitarians and fever experts of the country.—*Exch.*

MR. WALKER ELLIS, who has had charge of the branch of the William S. Merrill Chemical Company in this city, has gone to Dallas, Tex. Mr. F. E. Lewis, who is well known to the profession, takes his place.

DR. A. MAGUIRE, gentleman and physician, died at Jeannerette, July 7, 1899. Dr. Maguire has been a prominent figure in medicine in Louisiana for over forty years, in which time he served the South during the war. Dr. Maguire was born in Canada, but lived for fifty years in Louisiana and latterly in New Orleans, upon his retirement from practice. In Jeanerette business was suspended in respect to his memory on the day of his funeral.

DR. N. L. GUICE, one of Meridian's (Miss.) most eminent physicians, who came to Meridian from Natchez six or eight years ago, died very suddenly from heart failure July 7, 1899.

THE CROWLEY BOARD OF HEALTH met recently and elected Dr. F. R. Martin, president, and Dr. H. W. Carver secretary and ex-officio sanitary officer. The president and secretary were allowed salaries of $300 and $250 per annum, respectively. Shortly after this meeting the president of the board discovered an "Indian doctor" engaged in practice. Dr. Martin told the pseudo doctor that he would have to get out. He had been doing a land office business, but lost no time in leaving.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of DR. F. W. PARHAM, assisted by DR. F. LARUE, New Orleans.

APPENDICITIS: SHOULD EVERY CASE BE OPERATED UPON AS SOON AS THE DIAGNOSIS IS MADE? SHOULD THE APPENDIX BE REMOVED IN EVERY CASE?—From the *Journal of the American Medical Association* we abstract notes of a notable discussion on appendicitis which took place at the recent meeting of the American Surgical Association in Chicago. Dr. Maurice Richardson, of Boston, read a paper dealing with the subject from the conservative point of view. His conclusions were based upon the observation of a large number of cases treated by himself and hospital colleagues. The total number was 904. The total operations were 569, 331 of these being in the acute stage and 238 in the interval. The mortality of the acute cases was 21.5 per cent. Of the interval operations there was not a single death. Thus the mortality from all operations was 12.6 per cent. Of 189 cases not operated upon, 31 died or 16.4 per cent. Most of these cases were practically moribund when first seen. But it is to be said that most of the cases operated upon were also desperate. Had all acute cases been operated upon the mortality of cases operated upon would undoubtedly have been reduced, since most of the acute cases not operated upon would also have recovered with operation.

Deductions from mortality tables are misleading. It would be as unfair to conclude that because a long series of bad cases had died after operation, therefore no operation should ever be performed, as to conclude that because practically all the reader's acute cases unoperated on recovered (excluding the moribund cases) therefore no operation is ever necessary.

There is a wise middle course by which unnecessary operations are avoided and necessary ones are performed. In the initial stage severe symptoms of onset demand immediate operation. In many cases these symptoms may subside, but exploration is indicated because the general trend of a case can not be determined at one observation. Cases of mild onset may well wait until a second observation indicates its probable course.

The most important question is not whether to operate but when to operate.

In view of the great mortality after operation in the severe cases, of the disadvantages of the drainage necessary in septic cases, weakness of muscles, stretching of scars, hernias and the like, the time to operate is in the period of perfect health following the attack. In a large percentage of acute cases recovery from acute attack will take place and operation can be performed through a small incision which will not weaken the abdominal wall. Cases must not be watched and waited on, however, unless there are reliable signs of convalescence.

After the initial stage the question of intervention becomes more difficult. When observed on the second, third or fourth days severe cases should be operated on at once unless they are improving so rapidly that there is strong expectation of complete recovery and interval operation. Intervention is still more strongly indicated when the symptoms are increasing in severity. Operation is indicated, too, if after marked improvement the smptoms recur as if, though moderate, the case is not improving.

In the consideration of symptoms the local are to be regarded as of more value than the constitutional, which may be deceptive. The character and extent of pain, tenderness and rigidity are important as determining the width and depth of the area of infection.

The chief objection to operating in every case is the danger of converting a localized into a general infection. If the patient is improving, with a successfully localized peritonitis of considerable extent, especially if centrally localized, as in the pelvis, let operation be postponed until intervention can be safely practiced, because those cases comprise, in the absence of general peritonitis, the most dangerous ones. Moreover intervention becomes safer with a few hours or a few days' delay in improving cases:

(1) Because the general exudate, so easily infected during operation, becomes absorbed; (2) because the local exudate diminishes in size; (3) because walling off with gauze is practicable when the adhesions are firm, impossible when they are thin; (4) operation at once ruptures the localized peritonitis and starts the too often fatal peritonitis. Moreover, the patient's strength improves with the local improvement.

If the patient's condition do not actually improve, this serious danger must be deliberately encountered, because the localized peritonitis will probably do so by itself—*i. e.*, rupture, which is chiefly to be feared at operation. When there is a tumor situated to the right or directly under the abdominal wall, so that walling off with gauze is practicable, operation may be performed under conditions that would contraindicate operation when the tumor is centrally located or in the pelvis.

Cases on the verge of the grave should obviously be let alone on the ground that the simplest active intervention will turn the scales against the patient. In areas with firm walls simple drainage is preferable to removal of the appendix, because of the risk of causing general infection by separating adhesions. An attempt should always be made to remove the appendix whenever the peritoneal cavity has been opened, unless the patient's condition forbids long search. In many cases of abscess with firm walls, a slough will be found, which, on examination, will prove to be a necrosed or exfoliated appendix. In such cases no subsequent operation will be necessary for the removal of the appendix.

In the discussion which followed, Dr. Deaver took very strong ground in favor of operation, no matter when the case was seen, the only exceptions being acute active general peritonitis and collapse, and maintained that the appendix should be removed in all cases except in those where the bowel forming a part of the wall of the abscess had undergone necrotic changes, rendering the bowel friable and apt to rupture during the necessary manipulation. Most of the other gentlemen who took part in the discussion favored the position taken by Dr. Richardson. We believe most surgeons will agree in the main with the conservative views expressed by Dr. Richardson. Speaking for ourselves, we believe it would be, while far more radical, much safer to operate—when not contra-indicated by the condition of the individual himself—*before there had been any attack at all*, than to adopt the views so expounded and advocated by Dr. Deaver.* Dr. Richardson has done a vast service to the profession, and especially to suffering humanity, in thus so clearly out of his large experience formulating the indications for intervention and for non-interference.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller,
New Orleans, La.

The immediate and remote results of seventy-one Alexander and seventy-one suspensio-uteri operations. The technic of both operations is given at length, and the following general conclusions are drawn:

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*If the operation be really so devoid of risk in the first few hours, would it not be beter to remove the appendix in all healthy men before any attack of appendicitis had occurred?—a safe operation, surely preventive of the dangerous disease in the future. We prefer, however, to adopt the views of Richardson.

1. The Alexander operation is preferable to the suspensio-uteri operation because it seeks to support the uterus by its natural ligaments. 2. The Alexander operation is indicated in retroversion, retroplexion and retroposition without ovarian disease. 3. In retroposition with tight utero-sacral ligaments, posterior colpotomy, for the purpose of dividing the tight ligaments, may be performed with advantage together with the Alexander operation. 4. In ovarian prolapse, especially if the ovarian ligaments are long, the Alexander operation can not be depended upon to raise the ovaries into a normal position. 5. One round ligament is not sufficient to hold the uterus in place. 6. The Edebohls' operation, although requiring a longer time for its performance than the operation at the external ring, is the preferable operation, because by it the round ligament being uncovered in the entire length of the inguinal canal, is less liable to be broken; also, because this method does away with the need of anteverting the uterus bimanually in the course of the operation; and, finally, because of the secure manner in which the ligament is anchored and the inguinal canal closed, making subsequent hernia impossible.

7. Although the Alexander operation leaves two scars on the abdomen, they are so situated as to be covered by the pubic hair, and are subsequently less of a disfigurement than is one scar in the median line.

8. The suspensio-uteri operation is indicated in retroversions, retroflexion and retroposition, with ovarian or tubal disease, whether inflammatory affections or prolapse.

9. The best method of performing the suspension is by means of absorbing ligatures passed through the anterior and upper portions of the fundus uteri and through the parietal peritoneum and transversalis fascia only. Thus an elastic band is created between the parietes and uterus, which maintains the uterus in place and does not cause interference with the enlargement of the anterior fundus during subsequent pregnancy.

10. Suspensio uteri leaves but one weak spot in the abdominal parietes predisposing to hernia, instead of two, as in the Alexander operation.

11. In the great majority of cases neither operation is the cause of complication in subsequent pregnancy.

12. In all cases of doubtful diagnosis in which condition of

the ovaries and tubes can not be determined accurately, the suspensio-uteri operation is to be preferred to the Alexander operation.—BURRAGE—*Medical News.*

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

A NEW SIGN FOR THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.—Dr. Murat in describing this new symptom says it is a subjective one, *i. e.* discernible by the patient, but not patent to physical examination. It consists of an abnormal sensation experienced by the patient when speaking in a loud voice; the vibrations of the latter are distinctly felt in the tuberculous lung. In one case it was even observed that instinctively the patient would bring his arm tight against the chest on the corresponding side and immobilize it in that position to attenuate this troublesome resonance in the infiltrated lung every time he would be excited and speak warmly, thus using his arm as a veritable sourdine on the vibrating thorax. The physician of course must as a rule call the patient's attention to this symptom, for it comes on gradually and being painless it is hardly noticed. But if the physician questions the patients in that direction, compels them to observe, orders them to articulate some words during a brisk operation, some sharp and loud "hums!" they will find out then that the vocal vibrations are propagated in the left lung, for instance, while the sensation is in no wise perceptible in the healthy lung. The contrast is distinct, for it seems to the patients that only the vibrating lung is in communication with the larynix.

It would be difficult by this simple interrogation to precisely determine the location and extension of this resonance; yet, when it takes place in the apices the patients never fail to point it out.

This symptom is a natural consequence of the thickening of the parenchyma and belongs to the same order of signs as increased vibrations in consolidations and bronchophonia, but it is distinctly observed and noticed by the patients at a period by far earlier than the latter phenomena mentioned. One case is reported by Dr. Murat in which it was present at a time when the most careful consultation could not detect the slightest objective evidence of any morbid process.

Therefore, it is worth while pointing out the symptom, not only as an early sign, a very sensitive "discloser" of the disease, so precious when it begins in central nuclei of infiltration, but also as a permanent symptom, which should stand permanently in the more advanced period of pulmonary tuberculosis.—*Revue Médicale.*—*Gaz. hebd.*

Department of Therapeutics.

In charge of DR. J. A. STORCK, New Orleans, La.

PARALDEHYDE IN ASTHMA.—Dr. Macgregor says in the London *Lancet* of February 11, 1899, that as far as he has been able to find out, Dr. Mackie, of Elgin, was the first to suggest the use of, and to use paraldehyde for the relief of asthma. "The fact that paraldehyde is a sedative largely eliminated by the breath," led him to try its effect in the spasm of idiopathic asthma. He administered it in a number of cases with uniformly successful results, and found that it speedily relieved the spasm and induced sleep. Dr. Macgregor's attention was drawn anew to this a few months ago, and since then he has given the drug in a fairly large number of cases of idiopathic asthma and other forms of spasmodic dyspnea, and his experience confirms that of Dr. Mackie. Dr. Macgregor says that no drug in his hands has given such satisfactory results. In the treatment of hospital out-patients suffering from asthma, morphin hypodermically is out of the question, and it is not usually advisable to prescribe chloral in such cases. Paraldehyde is absolutely safe. It not only relieves the spasm, but it induces tranquil, refreshing sleep, without any objectionable after-effects. Besides, no evil results follow a prolonged use of paraldehyde; it does not give rise to a habit, and on this account it is a much more desirable drug than morphin or chloral. That it has hitherto not been much used in the treatment of asthma, one may safely conclude from the fact that neither in Allbutt's "System of Medicine," nor in "Twentieth Century Practice of Medicine," is it mentioned among the drugs given as useful in the treatment of the disease.—*The Therapeutic Gazette.*

GUAIACOL will render painless intramuscular injections of grey oil, oil with calomel, and especially oily solutions of biniodide of mercury, frequently employed for a long time in the treatment of syphilis. E. Bazin, of Bordeaux, regards it as sufficient to incorporate with the preparation to be used 3 per cent. of the purified drug. Here is the formula which Dr. Lagrange recommends in his supplementary course on ophthalmology in the Bordeaux Faculty of Medicine:

Sterilized olive oil	20 ℥.
Biniodide mercury	6 gr.
Synthetic guaiacol	36 gr.

Should the physician inject every day, or every second day, in the region of the thigh, say thirty grains of this solution, it will represent about one-quarter of a grain of the biniodide of mercury. It is a well-known fact that mercury salts, and particularly iodin-mercury preparations cannot be combined with cocain without precipitating the latter and rendering it useless as an anesthetic. All such remedies for hypodermic use will probably work well with guaiacol.—*Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING.

URTICARIA CAUSED BY CERTAIN ODORS.—In a recent communication to the French Laryngological Society, Joal, of Mont-Dore, reports three cases of urticaria that have come under his observation, the direct exciting cause of which was traced to the influence of certain odors to which these patients were peculiarly susceptible. In one of his cases, a neurasthenic man of twenty-six years, who gave a history of previous attacks during his boyhood caused by eating sweet-meats flavored with vanilla, it was found that when subjected to the odors of anise, English mint, hyssop, canella, and such aromatics used in the preparation of liqueurs, of which he was a manufacturer, he would be immediately affected with severe attacks of sneezing and rhinorrhea soon followed by a general eruption of urticaria. The author had occasion to produce an attack of this kind voluntarily, with the consent of the patient, and proved beyond doubt that the eruption was due to the irritation of the olfactory nerves.

The other two cases were subject from the same cause to attacks of hyperesthetic rhinitis associated with asthmatic dyspnea and urticaria. In a careful review of the subject of urticaria in dermatologic works the writer has failed to find any mention of odors as being a causative factor in the etiology of the affection, nor does any treatise on rhinology take note of the fact in the study of odors and olfaction. He has, however, found a few observations relating to the subject which afford additional proof of the correctness of his theory. These attacks of urticaria are classed among those well known reflex phenomena, such as hay-fever, rhinorrhea, asthma, migrain, vertigo, etc., which in many instances can be traced directly to intranasal irritation. In the cases observed there was found the usual state of hypersensitiveness of the pituitary membrane of the nose with hypertrophy of the erectile tissue and treatment of the local condition markedly modified the reflex disturbances. The irritation of the olfactory filaments is propogated to the nerve centres by means of the trifacial, which in this condition is hypersensitive.—*Revue Hebdomadaire de Laryngologie.*

THE USE OF MENTHOL-PHENOL-COCAIN COMPOUND AS A LOCAL ANESTHETIC IN OTO-LARYNGOLOGY.—A. Romain, of Brest, has written two papers advocating the use of a new local anesthetic mixture which he has employed extensively in nose, throat and ear work with very satisfactory results, especially in those cases in which the use of ordinary cocain solution is insufficient to relieve the pain.

Two formulæ are employed, one containing equal parts of crystallized carbolic acid, cocain hydro-chlorate and menthol, is simply anesthetic and analgesic; the other contains two-thirds of crystallized carbolic acid to one-third each of cocain and menthol, and is employed as a caustic and anesthetic. Menthol here plays the peculiar role of liquefying the carbolic acid crystals, and when the cocain is added the result is a syrupy liquid compound of a slightly yellowish color. In the ear it is employed most successfully to anesthetize either the auditory canal, drum membrane or tympanic cavity—parts that are but slightly affected by simple applications of cocain. In acute external and middle ear inflammations a pledget of absorbent cotton saturated with solution No. 1, introduced into the canal and left in contact with the drum membrane will effectually relieve the pain and allow the canal or membrane to be incised with the least amount of suffering. Curettement of the tympanic cavity and removal of the ossicles in chronic middle-ear suppuration can be readily performed under anesthesia thus obtained.

In the nasal fossæ, pharynx and larynx it is applicable to those operations requiring only a limited area of anesthesia, as in exploratory puncture of the maxillary antrum, adenotomy, galvanocautery of the turbinates, lingual tonsil and epiglottis, and to relieve the dysphagia of tuberculous laryngitis.

The caustic mixture the author employs as a substitute for trichloracetic acid in the ear and as a caustic for tuberculous ulcerations and vegetations.

The three qualities of anesthetic, mild caustic, and energetic antiseptic make these mixtures valuable adjuncts to our resources. —*Revue Hebdomadaire de Laryngologie, de Rhinologie, etc.*

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Practical Treatise on Fractures and Dislocations. By LEWIS A. STIMSON. Lea Brothers & Co., New York and Philadelphia, 1899.

The author says in his preface: "Although this work is, in one sense, a second edition of the volumes published in 1883 and 1888, it has been so largely rewritten that it is practically new." As it stands now it can be truthfully said that it is the best guide in the English language in the study and treatment of fractures and dislocations. The views as expressed are the result of a very large experience, and the advice given may be depended upon as reliable and judicious. This is shown in the estimate he draws of the value of the X-rays in the study of fractures and dislocations. "While," he says, "the X-rays have been of interest and value in showing details of certain fractures, especially at the wrist, elbow and ankle, yet it cannot fairly be said that they have yielded much information of practical value, which could not have been obtained by palpation "

PARHAM.

An Experimental Research into Surgical Shock. An Essay awarded the Cartwright prize for 1897. By GEORGE W. CRILE, M. D., Ph. D. Philadelphia, J. B. Lippincott Co.

This is a work of 160 pages, embodying the essential facts of 138 experiments on unselected dogs, taken in regular order as they were supplied by the laboratory servant. These experiments are followed by a summary of the experimental evidence, considered first with regard to the particular tissue injured by the shock-producing agent; then the differnnt regions are discussed. The factors causing shock are considered under the following heads: Duration of operation, temperature, physical condition, anesthesia, hemorrhage, vasomotor change, cardiac changes and post-mortem appearances. The author finally discusses the prevention of shock and the treatment of shock. Every phase of the subject is illustrated by a chart, which is a summary of all the observations made on that phase, expressed in terms of a mercurial manometer. He makes a distinction between collapse and shock, reserving the latter term for the later depression due to a *vasomotor* impairment or breakdown, although the cardiac and respiratory factors may be of considerable importance. In shock there is really a bleeding into the veins, as Dawbarn has recently very emphatically pointed out. The whole work is worthy of careful study, and will give one a broader and more comprehensive view of the subject of shock than can be obtained at the operating table alone, at perhaps the expense of some human lives. PARHAM.

Cyclopædia of the Diseases of Children, Medical and Surgical. Articles written for the work by American, British and Canadian authors. Edited by WILLIAM A. EDWARDS, M. D., Vol. V, Supplement. J. B. Lippincott Company, Philadelphia, 1899.

This pioneer in the fields of pediatrics is maintained in a state of eternal validity, for it stands now as ever abreast with the times. It is even possible to find in this book some statements of recent date such as the additional note to the excellent article on malaria, concerning the diagnosis of malaria wherein it is said: "A safe, conservative estimate of our present position would force us to the admission that our etiologic knowledge is not sufficiently complete to warrant its application as a final conclusion *to all cases*, etc." "One can die of a malarial affection positively diagnosticated without the presence of the well-known hæmatozoon in the blood" (Bacelli). "There are such thoughtful remarks in the work taken from recent literature. In fact a feature of the book is its reading references which in some instances are a complete bibliography on the subject. It is a pleasure to find among the collaborators one of our local men, Dr. Matas, who contributed his excellent article, "The Surgical Treatment of Congenital Ano-Rectal Imperforation."

The book is not written after a pre-arranged plan of didactic classification, but it is a collection of articles on subjects special or common to the infant and child. It is a very good book. DUPAQUIER.

An American Text-book of the Diseases of Children by American Teachers. Second Edition. Edited by LOUIS STARR, M. D., assisted by T. L. WESTCOTT, M. D. W. B. Saunders, Philadelphia, 1898.

It is a fact that the general practitioner is more deeply interested in pediatrics than in any other branch of medicine and a good working book at home goes far to make him happy. The information gathered in the present edition of this standard work supplies the needs of practice. A number of articles have been rewritten and valuable additions make the book still more didactic. The following prints are noted: Bathing the babe in the old fashion is still advocated, no allusion is made to the use of oil or alcohol instead of water. Infant foods are not too strongly condemned and for all the pages on feeding, a strong plea for fresh milk would seem more appropriate. Artificial feeding with modified milk is the subject of a very scientific article, but it is actually hard, if not impossible, to always carry out the procedure in practice. The wet nurse in more than one instance would prove an easier plan. Over-sterilization, the misuse of sterilization of milk is justly condemned in the article on scorbutus wherein a new cut shows the characteristic attitude of the legs in infantile scurvy. It is altogether a source of pleasure to possess in a very neat book like this a number of articles from the pens of our prominent American pediatrists. DUPAQUIER.

PUBLICATIONS RECEIVED.

Progressive Medicine, Vol. I, edited by Hobart Amory Hare, M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

Practical Diagnosis, 4th edition, by Hobart Amory Hare, M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

A Manual of Surgical Treatment, by W. Watson Cheyne, M. D., F. R. S. C., and F. F. Burgherds, M. D., F. R. C. S., Vol. I.—Lea Bros. & Co., Philadelphia and New York, 1899.

Tulane University of Louisiana Announcement, 1898-1899.

Hay Fever and its Succeesful Treatment, by W. C. Hollopeter, A. M., M. D., 2d edition.—P. Blakiston's Sons & Co., Philadelphia, 1899.

The Woman's Medical College of Pennsylvania Fiftieth Annual Announcement, 1899.

Southern Surgical and Gynecological Society Transactions, Vol. II, 1899.

Prophylaxis and Treatment of Pulmonary Tuberculosis, Alvarenga Prize Essay for 1898, by S. A. Knopf, M. D.—P. Blakiston's Son & Co., Philadelphia, 1899.

Public Health Reports for June, Washington, D. C.

A Manual of Diseases of the Nervous System, by Sir W. R. Towers, M. D., F. R. C. P., F. R. S.—P. Blakiston's Son & Co., Philadelphia, 1899.

The Mineral Waters of the United States and Their Therapeutic Uses, by James K. Crook. A. M., M. D.—Lea Bros. & Co., New York and Philadelphia, 1899.

REPRINTS.

Appendicitis or Salpingitis, With Complications, and a Report of Some Unusual Cases.—An Improved Method for Removal of Intraligamentous Cyst, by Thomas H. Hawkins, A. M., M. D.

An Act to Provide for the Care, Control and Treatment of Inebriates, and for Purposes Incidental to the Above Mentioned Objects.—Legislative Council and Legislative Assembly of New South Wales.

Charbon, or Anthrax, With Experience During Recent Outbreak in North Louisiana. by Dr. S. B. Staples, D. V. S., and Dr. W. H. Dalrymple, M. R. C. V. S.

The Effect of Pressure in the Preservation of Milk—a Preliminary Report, by B. H. Hite.

Gynecologic Diseases; Gonorrhea in Women; Treatment of Endometris; Tampoons and Pessaries in the Treatment of Displacement of the Uterine, by T. J. Watkins, M. D., Chicago.

The Responsibility of Physicians, by Robt. W. Faulk, M. D.

The Symbolism of Medicine, by Col. French R. Stone, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR JUNE, 1899.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	6	8	14
" " Intermittent			
" " Remittent	1		1
" " Congestive	1	1	2
" " Typho	2	3	5
" Yellow			
" Typhoid or Enteric	16	5	21
" Puerperal			
Influenza			
Measles	1		1
Diphtheria			
Whooping Cough			
Apoplexy	11	6	17
Congestion of Brain	5	2	7
Meningitis	12	6	18
Pneumonia	11	11	22
Bronchitis	4	7	11
Cancer	8	3	11
Consumption	31	46	77
Bright's Disease (Nephritis)	28	15	43
Uremia			
Diarrhea (Enteritis)	64	24	88
Gastro-Enteritis	7	9	16
Dysentery	9	8	17
Hepatitis	2	3	5
Hepatic Cirrhosis	2	3	5
Peritonitis	2	4	6
Debility, General	1	2	3
" Senile	8	13	21
" Infantile	5	7	12
Heart, Diseases of	35	21	56
Tetanus, Idiopathic			
" Traumatic	3	2	5
Trismus Nascentium	4	1	5
Injuries	9	4	13
Suicide	2		2
All Other Causes	178	66	254
TOTAL	458	280	738

Still-born Children—White, 13; colored, 18; total, 31.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 26.17; colored, 37.33; total, 29.52.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.04
Mean temperature	80.00
Total precipitation	7.80 inches

Prevailing direction of wind, southeast.

NEW ORLEANS
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VOL. LII. SEPTEMBER 1899. No. 3.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

THE IMPORTANCE OF THE EARLY RECOGNITION AND TREATMENT OF CATARRHAL DISEASES.*

BY W. SCHEPPEGRELL, A. M., M. D., PRESIDENT WESTERN OPHTHALMOLOGIC AND OTO LARYNGOLOGIC ASSOCIATION, ETC., NEW ORLEANS, LA.

The reading of a paper on the importance of the early recognition and treatment of catarrhal diseases before an association of physicians, who have long since accepted the subject of the title as an axiom in their routine work, would seem almost to demand an explanation, if not an apology. It must be remembered, however, that while those members of our profession whose special experience has taught them to feel the importance of this subject, it is by no means realized by physicians in general. It is a most frequent experience with us all to examine cases in which the prognosis is seriously affected by the neglect in realizing the importance of early treatment, not only on the part of the patients themselves or their relatives, but even of the family physician whom they may have consulted.

As in many other pathologic conditions, the fallacious theory that the patient will outgrow the condition from which he is suffering has been responsible for many cases of defective hearing and serious throat and chest affections;

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*Read before the annual meeting of Western Ophthalmologic and Oto-Laryngologic Association, New Orleans, February 10 and 11, 1899.

which could have been relieved by an early recognition and treatment.

As a representative body of physicians who devote their time and energy to the advancement of the methods of diagnosis and treatment of the diseases which form the subject of the title, it is our duty to call attention to this matter and to emphasize it by a discussion, thus indicating its importance to the profession at large. This is my object in presenting this communication more than to throw additional light on the subject, the importance of which has long since been recognized by the modern laryngologist and otologist.

The prevalence of catarrhal diseases in adults, and the obstinacy of these cases when the affection has been of long duration, demonstrates the importance of an early recognition of these affections, or such conditions which predispose to catarrhal diseases, at a time when they are easily amenable to treatment. According to our present standard of nosology, the term "catarrhal diseases" may be considered indefinite, but it expresses more fully than any similar term the pathologic conditions under discussion, or at least prevents a great deal of circumlocution.

The careful examination of children in recent years has demonstrated the fact that conditions often exist which attract but little attention on the part of the patient or the parents, but form a foundation for serious catarrhal diseases in later life. These affections concern not only the nose and throat, but also the ear, whose close physiologic and anatomic relation causes it to be easily influenced by catarrhal diseases.

The pathologic conditions most frequently found in the nose and nasopharynx of children are the enlargement of the pharyngeal tonsil and the various forms of rhinitis. When the hypertrophy of the pharyngeal tonsil is so marked that the respiratory function of the nose is inhibited, the diagnosis is easily made and the treatment, the radical removal of the obstruction, at once suggested. Frequently, however, the lymphoid tissue is not sufficient to form a mechanical obstruction to breathing directly, but causes this by setting up congestion in the nasal chambers so that the effect on the throat and the body in general is sometimes marked. It differs from the obstruction due directly to the adenoid tissue in the nasopharynx chiefly by greater variations of the difficulty of breathing due to the vascular changes in the mucous membrane of the nasal chambers. In another class of cases, the lymphoid tissue is an etiologic factor in the formation of abnormal secretions which endanger the integrity of the Eustachian tube and other neighboring parts.

When these cases are neglected, even where they do not set up inflammatory complications in the ear or throat, a contraction of the nasal passages frequently presents itself, due to defective development, which forms a condition difficult to eradicate.

The question of the treatment of enlargement of the pharyngeal tonsil is one that frequently taxes the judgment of the physician. It would be almost erroneous to operate in every case of hypertrophy of the pharyngeal tonsil as it would be to neglect every case in which this condition presents itself. Experience and careful observation alone must determine in the particular instance whether the case demands a radical operation or milder treatment.

If we eliminate inflammatory processes due to specific affections, tuberculosis, lupus, leprosy, etc., the condition which presents the greatest possibilities for injurious effects in children is purulent rhinitis. The muco-pus which is secreted is often retained in the nasal passages in small children, and by its irritation directly, and indirectly by forming a culture ground for pathogenic germs, effects serious injury on the normal structure of the nasal passages. Although this is disputed ground, observation and experience have convinced me that it is frequently a forerunner of atrophic rhinitis, an affection most obstinate to treatment and severe in its results, on account of its effect on the whole respiratory function, and even on the general health.

Many affections of the ear are insidious in their development and frequently do not come to the attention of the aurist until such pathologic changes have been effected that an absolute cure may be impossible. Where a case of otitis media develops with severe pain and febrile reaction, the patient consults an aurist promptly enough, but the majority of cases develop without any painful symptoms, the progress of the disease being recognized only by a feeling of discomfort due to obstruction of the Eustachian tube, tinnitus, slight loss of hearing, etc., and here again the fatal error is frequently made that the patient will outgrow it, or that it will "become better of its own accord." Many of our most discouraging cases develop in this way.

My object in referring especially to these conditions is that they are so often overlooked by the patient or the parents, and even by the family physician. The obstruction of respiration shown by the mouth breathing of children is usually considered a "bad habit;" the defective hearing "lack of attention," and the purulent rhinitis only a "cold." As these conditions are not usually considered of sufficient importance to demand the aid of the aurist or laryngologist, they are frequently neglected until they have become so aggravated as to effect serious and even permanent injury.

It is true, it must be admitted, that the adenoids in the naso-pharynx, which may cause so much irritation, will eventually atrophy, but, unfortunately before the process is completed—which is not before the patient is 20 to 30 years of age, and I have seen the hypertrophy still existing at a later period of life—such serious injury may have been effected as to resist all treatment in later years. Many cases of ozena, ethmoidal and antral disease, naso-pharyngeal catarrh, defective hearing and serious affections of the middle ear owe their existence to the neglect of treatment of an apparently insignificant affection in childhood, which could have been easily and quickly remedied by proper treatment.

The subject of this title covers so vast a territory that I must need of necessity limit myself to a few of the most important points, and more especially to the importance of the recognition of these conditions in early life. The subject, however, could be so developed and discussed that it would fill an octavo volume.

We all recognize, for instance, the serious difficulty of curing chronic suppurative affections of the accessory sinuses. The acute form of these diseases, however, presents little difficulty and usually gives the most satisfactory results. Nasal obstruction due to deformities of the septum, hypertrophy, etc., are usually corrected by one experienced in this line of surgery without difficulty, while many of the lesions due to the neglect of such interference are of the most obstinate character.

When the profession at large realizes the importance of this subject, and the laity appreciates the necessity of maintaining the normal condition of the respiratory passages and realizes the danger of any deviation from this standard, the number of incurable cases and those in which the results are unsatisfactory will diminish rapidly. That the day is not far distant when this will be the case is demonstrated by the every-day experience of our hospitals and offices. It is already no uncommon occurrence for parents to present their children for examination because they breathe through the mouth, or suffer from the early stage of catarrhal disease; but the number is still sadly in the minority In the majority of cases the treatment has been deferred for months or even years without any reasonable excuse, except the faith in the belief that the patient would outgrow the affection. Such cases are fortunate if the neglect has not brought on some secondary changes in which the prognosis for recovery is discouraging. We should, therefore, continue to impress upon our patients and the medical profession in general the importance of the early recognition and treatment of catarrhal diseases.

SOME FOOD IMPURITIES AND CHEMICAL PRESERVATIVES.*

BY QUITMAN KOHNKE, M. D., CHAIRMAN AND HEALTH OFFICER OF THE BOARD OF HEALTH OF THE CITY OF NEW ORLEANS.

Man, in his primitive state probably had few wants, few desires and burdened himself with few responsibilities. To protect himself and his immediate family from hunger and thirst, the elements and the depredations of savage beasts, including his human neighbors, was doubtless his highest ambition. Disease and death were foes of unknown nature against which no measures of defence could be adopted. Happy was he who had enough to eat and drink, a shelter and weapons of defence; all the product of his own brain and brawn; his own skill and labor; his own good fortune in hunt or husbandry. Responsible to himself for the result of his own efforts, with none to be blamed for failure, an intense familiarity with every detail of his life and living was inevitable, and a dependence upon others for his slightest needs unthought of.

How different is the dweller in cities of to-day; dependent upon others for every need; having no control, except imperfectly through others, over the necessities of life, while reaching out, as it were, over thousands of miles to secure the furnishings of his breakfast table, from people he does not know, never saw and does not care to meet; whose interests are not his welfare but their own profit.

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* Read at Orleans Parish Medical Society, July 22, 1899.

Given these conditions without the restricting influence of food laws and breakfasting might become an exceedingly dangerous experiment. It is not entirely devoid of danger as it is, for no law is perfect or perfectly enforced, and the need for more stringent laws better enforced is increasing daily. This need will not be adequately supplied by legislative bodies until the education of the public, in this regard, excites a demand upon its chosen representatives.

The medical man, more easily and more properly than any other, can spread the gospel of pure food; whenever our profession has urged upon legislators a measure intended for the public good and which lay within the province of our judgment, success has been the final result.

It behooves, I believe, every medical man to study by personal observation the possible relationship between impure food and diseases of obscure origin.

The relationship between ptomains and gastro-intestinal diseases is, in a general way and in theory, well recognized, but in daily practice it is probably overlooked more often than observed.

It is suspected, and has been charged, that meat which has begun to undergo decomposition and can not for that reason be sold as fresh meat, is pickled or otherwise prepared for market.

The first indication in refrigerated meat, of decomposition is what is called "souring." The "sours," it is charged, are utilized as prepared meat. "Souring" is a ptomain-producing process, and ptomains being alkaloidal in their nature, are not destroyed by the usual process of preparing meats—nor indeed by any other to which meat is put.

Cooking will destroy most bacilli, bacteria and germs of disease generally, and even spores, but ptomains, once formed and deposited, remain unchanged. Can we say that there is not much more ptomain poisoning in our daily practice than is recognized?

May not certain nephritic conditions be due to the constant ingestion of salicylic acid unaccompanied by an alkali?

May not certain gastric and intestinal diseases met with in daily practice be caused by impaired digestion due to the presence of food impurities in the shape of chemical preservatives?

That the use of chemical anti-ferments has increased enormously of late years is beyond question.

The brilliant example of "embalmed beef," so thoroughly advertised by the press of the country, and so superficially and unsatisfactorily investigated by the government, is only a sample of what may be discovered by a thorough examination of other food products. It may be discovered that cupidity and ignorance have conspired to poison more people than war destroys.

Milk is a food that is more frequently, probably because more easily, adulterated than any other.

When we reflect that nearly one-third of the children born in this country die under five years of age, and that the main diseases of children are intestinal and respiratory, we may well consider that the laws safeguarding this food supply from contamination are imperfect.

When we are told that butchers fear to buy dairy cows for slaughter because they are almost invariably rejected by the meat inspectors as tuberculous, we may well believe that the milk inspection is not complete that does not include the cows from whence the milk is derived.

When we see tuberculosis in the mortuary records at the head of the list of death-causing diseases, a preventable disease, we may well wonder why something is not done to correct what is so palpably wrong. If, however, we have occasion to witness the struggles of a sanitary law, trying to come forth from legislative halls against the opposition of "blind prejudice," "conservatism" and "vested interests," we may cease to wonder.

Laws of the kind needed to protect our food supply can be and will be enacted, but not without persistent and untiring effort on the part of men whose unselfish interest in the public welfare is greater than the natural desire for peace and quiet that reposes in the breast of the average citizen.

The character of some of the purveyors of this most important food, upon which tender infants rely for sustenance, was well shown not a long while ago in one of our recorder's courts by the testimony of several milk vendors who unblushingly confessed to a deliberate adulteration of their milk with water whenever the assurance could be obtained that no inspection of their output would be made on that day.

Let this be considered in connection with the well-known fact that many of our dairies are supplied with the most impure water, and the origin of some of our cases of infant diseases may be vividly imagined.

Aside from the impurities due to admixture of milk with germ-laden water, we have to deal with chemical adulteration, mostly boracic and salicylic acids and formaldehyde.

The manufacture of preservatives "to keep milk sweet" is a more extensive industry than is generally supposed. Tablets and powders and liquids made up of chemical anti-ferments are advertised under proprietary names suggesting innocent use, such as "preservaline" and the like. These chemicals do, of course, preserve for a time milk and other organic substances from fermentation and decay, and would seem, to the uninformed, quite harmless ingredients whose presence is a great benefit, inasmuch as the milk which contains them is received by the consumer in a palatable state "fresh, pure and sweet."

A closer observation, however, and a more intimate knowledge of the subject would disturb this conclusion.

Why is milk subject to alteration, and what is the nature of the change that takes place?

We know that milk taken from a healthy cow and placed in a sterile receptacle protected from the air will keep indefinitely. This condition of asepsis is not possible ordinarily, but it proves that souring and the other changes usually observed in milk depend on outside influences.

The presence of living organisms which have entered the milk after it has been taken from the cow causes the changes so objectionable to the consumer and so disastrous to the business of the vendor. It is reasonable to suppose that a larger addition of organic life will more quickly produce the undesirable changes, and, therefore, clean milk well protected from the germ-laden air will last longer than milk drawn and kept under less favorable conditions. It follows, then, that the dirtier the surroundings, the more will the milk require chemical preservatives to insure its delivery in apparently proper condition. This view of the matter would cause the presence of chemical preservatives in milk to bring about its condemnation.

Whether or not the presence of a small quantity of an anti ferment in food is injurious is a question upon which, apparently, competent authorities are not united.

It would seem at first glance that, as digestion is essentially a fermentative process, the presence of an inhibitive chemical, even in very small proportions, would prolong the time required to prepare food for assimilation, and the constant repetition of this disturbance to digestion may eventually effect serious changes in delicate organs. Unless, however, this can be fairly well proven, lawmakers will be chary in interfering with commercial interests. It may be questioned whether these chemical additions to a food product could be included under the broad head of "adulteration." A court of justice would be inclined, perhaps, to require proof of hurtfulness. It is important that this proof be established, if possible.

There is now under consideration by the local Board of Health the use of chemical preservatives in meats imported from the West, and possibly these meats will be declined in this market.

It is probable that litigation will result from our refusal to admit chemically-treated meat; and, if this should be the case, a powerful combination of moneyed interests and legal talent will be arrayed against the Board, "*Salus populi suprema lex,*" but not infrequently commercial interests have, for a time at least, the inside track.

THE LESSONS OF THE YELLOW FEVER IN NEW ORLEANS IN 1879—FORTY-ONE CASES AND NINETEEN DEATHS—CRUDE SCIENTIFIC SANITATION AND NO QUARANTINE.

BY EDMOND SOUCHON, M. D., PRESIDENT LOUISIANA STATE BOARD OF HEALTH, NEW ORLEANS.

After the lapse of twenty years, the reading of the events of the year 1879, concerning the yellow fever of that year, proves to be replete with the most vivid interest to the sanitarian and to the student of evolution of principles and of methods.

It is a banner year, an epoch-making year. It marks the end of continuous yellow fever in New Orleans from year to year. It is the dawn of the era of disinfection—*i. e.*, of scientific sanitation, whose primitive and crude methods, passing through the irresistible genius of our own Joseph Holt, have finally culminated in the brilliant work of to-day at the Mississippi River Quarantine Station, in the splendid achievements of the United States Marine Hospital Service under the Atlanta regulations and in the marvelous and comforting result, in 1897, of the Isolation Hospital, Touro Infirmary and Hotel Dieu, in the thorough controlling of the spread of the disease by unrelenting, vigilant disinfection—*i. e.*, the destruction of the germs as fast as they leave the patient through their secretions and excretions. The results at the Touro, where no case originated, were particularly striking. There, Dr. Loeber states over his signature that he did not even isolate the cases. He placed them in the wards among other patients, but he was particularly watchful of disinfection. He did not allow the students and the nurses to go into the city as long as the epidemic lasted, as they might contract the disease and bring it into the place.

In proof of the foregoing assertion that the year 1879 was practically the last year of continuous yellow fever in New Orleans, we quote the following:

1879	19	Deaths.	1885	0	Death	1891	0	Death.
1880	2	“	1886	0	“	1892	0	“
1881	0	“	1887	0	“	1893	0	“
1882	4	“	1888	0	“	1894	0	“
1883	1	“	1889	0	“	1895	0	“
1884	1	“	1890	0	“	1896	0	“

See Reports of the Louisiana State Board of Health.

See also an Epitomized Review of the Principles and Practice of Maritime Sanitation, by Joseph Holt, M. D., former President of the Louisiana State Board of Health, 1884–1888.

The following report of the yellow fever of the year 1879, in New Orleans, by Dr. Robert A. Bayley, then the sanitary inspector for the Fourth District, tells, with admirable but forceful simplicity, the tale of that historic year:

“This district was the only infected one in New Orleans, to any extent, as well as the field for active sanitation connected therewith. The locality can in itself be restricted to that portion lying between Chestnut street and the river, and between First and Eighth streets. Later on in the fall three new localities in the rear of St. Charles street were invaded, but the disease did not spread there.

“The first authentic case of yellow fever reported last summer, July 26, occurred at the corner of Second and Constance streets, in the Spano family. The Board of Health, realizing the danger and importance associated with this malignant case of fever, did everything in their power to eradicate the infection *in situ;* they erred, however, in supposing this was the only focus of infection at that time, as subsequent events have well proven. Disinfection and isolation were fully carried out. After the death of the girl, Vincenza Spano, the soiled bedding, clothing, mattresses, etc., belonging to the family were burned at once, and the house and premises fumigated. The Auxiliary Sanitary Association commenced the inspection and disinfection of premises around this infected square the day following this death and carried on the work in lines radiating therefrom.

"Dr. Mainegra, after reporting the first case of fever, then reported his own child, Carrie S., as having been sick since July 22, making the latter case the first one in reality.

"These cases of fever, occurring as they did in stores (fruit and drug), can be traced to the cases of supposed remittent fever in the Stout family, No. 184 Third street, the members of which, seven in number, were taken sick in immediate succession, from June 16 to July 17, and that, very likely, was brought about by direct or mediate intercourse between the families (the Stout cases are now recognized as yellow fever).

"It is known that no case of fever occurred in 1878 either in the Spano or Mainegra houses, and there was a case and death from yellow fever late in the season in a family living at that time in the house until recently occupied by the Stouts. No member of the Stout family had yellow fever, to their knowledge, before last summer, when an infectious fever, remittent in character, attacked each and every one of them. The fact of the Creel girl dying from unmistakable yellow fever a few days after leaving their house removes all further doubt on this question.

"From July 30 to August 16, a period of two weeks, the district remained free of infection, to all appearances. From August 16 to September 1 no less than eleven cases of fever were reported, and all in the designated infected section of the district. In the month of September three cases of fever occurred, the third case being reported three weeks later than the first two, and in an entirely new locality, at Captain Menge's, No. 300 Jackson street. Three out of five cases in October occurred in the rear of St. Charles street, but the disease ended in a sporadic manner in each of these new localities. The fever died out, or was killed out rather, before the month of November.

"As fair examples of the efficiency of disinfection, when thoroughly and properly carried on, the sanitary measures so actively instituted at the Spano, Hood, Mattheuse and Menge residences, may be mentioned in particular. They were foci of infection, and, as such, were destroyed by persistent sanitation in detail. This assertion may be made, though in a less positive manner, in other cases, owing to the non-co-operation of the physicians in attendance in a great measure.

"The work of disinfection and cleaning, done on the streets and in premises by the Auxiliary Sanitary Association and National Board of Health, accomplished much in the way of saving the city from an epidemic of yellow fever. The remarkably cool summer may have been an important factor in bringing about this result. It surely was not owing to a lack of fever material, as there were more than enough of the unacclimated to furnish subjects for the infection, had the disease once fairly got started.

The sad experience of Memphis for the past two years is sufficient to satisfy any one on that subject.

"The clothing, bed coverings, mattresses, etc., used by yellow fever patients after recovery or death, were in almost every instance submitted to fumigation, for a space of six hours, and then boiled for a half hour in strongly disinfected water. The mattresses were ripped open for this purpose. The mattresses of the Hood and Mattheuse families were covered over with disinfected tarpaulin, and carried out to the dumping grounds to be burned; those saved from burning in other places were made over after disinfection and fumigation. The chloride of lime placed in dishes and then moistened with water was used in the death room, whenever there were others sick in the house and likely to be injured by the fumes of the stronger agent, sulphur; otherwise, the sulphur fumes were used instead. The privy-vault, drains, alleys, etc., connected with infected premises, were disinfected immediately. Isolation was practised as much as possible. The bodies of those dying at the Hood, Mattheuse, Berkson and Menge houses, were, by order of the attending physician, placed at once in wooden coffins, containing about three inches deep all around of pulverized charcoal, and the coffins deposited in suitable boxes with charcoal in sufficient quantities to cover them entirely. This manner of disposing of those dead is a matter for the thoughtful consideration of physicians in this city, and should control their actions in these premises hereafter. By thus secluding the corpses of yellow fever patients from contact with the surrounding air, not only in the place of habitation but in the public thoroughfares as well, the danger of spreading the infection would be proportionately lessened in degree. In each of the cases just mentioned, the family was easily persuaded to delay the publication of the death of the member until after the funeral; and, by so doing, these funerals were not largely attended.

"The crowding of the friends and relatives, who are unacclimated, in such infected houses, can not be too strongly discountenanced. It was always a delicate matter to suggest and accomplish this mode of isolating the dead from those related to them; and, therefore, it required the active assistance of the family physician to remove prejudices.

"Yellow fever was arrested last summer (1879), if not immediately destroyed in its very commencement, by cleanliness conjoined with disinfection." (Report of Louisiana State Board of Health for 1879, dated January 1, 1880.)

QUARANTINES.—The quarantines of that year, 1879, did not amount to much, especially when compared with the previous year of 1878.

The records of the Louisiana Board of Health make no mention of any, neither do the files of the New Orleans papers, except that Galveston quarantined New Orleans because New Orleans had raised the quarantine against Memphis, as evidenced by the report of the medical inspector of the board, Dr.

C. L. Horton, who has made a diligent search through both the board's records and the newspapers of that year.

However, Dr. Stanford E. Chaillé, then a member of the National Board of Health, kindly informs me (by letter) that New Orleans quarantined that year against Memphis, Morgan City and Mississippi City, and quarantine measures were adopted to protect other places from New Orleans.

The quarantine measures were executed by the National Board of Health, the State Boards co-operating.

These measures were the establishment of sanitary inspection for freight and passengers on railroads and river crafts, and these measures prevented "a rigorous policy of non-intercourse," specially on the part of Mississippi and Tennessee.

It is entirely proper to assert, in the light of what has since occurred, that the circulars of the State Boards of Health of Mississippi and Tennessee averted a panic, prevented the interruption of travel and traffic, and restored confidence throughout the Valley of the Mississippi in many communities, which have not yet forgotten the history of the year 1878. (See Report 26, National Board of Health, 1880, pages 59, 60.)

The orders of the State Board of Health of Tennessee and Mississippi show the following:

> "First—That on and after the date of this publication no freight car over any railroad, nor any steamboat or other water craft departing from the city of New Orleans after the fifteenth day of July, 1880, and until further orders, shall be allowed to enter the State of Tennessee, nor to make a landing upon the borders of the State for the purpose of transacting any business whatsoever, unless said car, boat or water craft shall present to the proper officers of this board a certificate from an officer or agent of the National Board of Health to the following effect:
>
> (*a*) That said officer or agent of the National Board of Health has personally examined the freight of such car, or the cargo, passengers, officers and crew of such steamboat or water craft, and has satisfied himself of the freedom from infection of said vehicle and its contents (persons and things).
>
> (*b*) That the freight or cargo comprises none of the following articles of the list recommended by the Louisiana State Board of Health to be subjected to obligatory quarantine and purification, to-wit: Clothing, personal baggage and dunnage, rags, paper stock, hides, skins, feathers, hair, and all other remains of animals; cotton, hemp, woolens, and coffee, nor any of the following additional articles, which are hereby declared contraband of quarantine in this State, to-wit: Second-hand bedding, clothing, upholstered furniture and textile fabrics, moss, jute and "excelsior," tropical fruits and productions.

"Second—That any of the articles above enumerated may be shipped as freight from New Orleans, and transported through the State of Tennessee by rail, if carried in close box cars, securely locked, and in charge of an officer or agent of this board. The expense of such officer or agent shall be defrayed by the railroad transporting such goods.

"Third—That this order shall be enforced on the railroad at the southern State line by the officers of the board appointed for such purposes; and at Memphis, and elsewhere upon the Mississippi river, by the wharfmaster, or other duly authorized officer. (See report National Board of Health, 1880, pages 59-60.)

"THE NATURE OF THE INSPECTIONS, AND THEIR EFFECT UPON THE COMMERCE OF THE MISSISSIPPI VALLEY.*—In anticipation of closing the stations on the 30th of September, a circular letter was addressed to the inspectors in charge on the 18th of that month, instructing them to forward, with their detailed reports of the operations at their respective stations, concise statements of their views concerning the service. (A) From the standpoint of preventive medicine, as tending to secure (1) a better sanitary condition of vessels; (2) a heightened sense of public health responsibility among shippers and common carriers; (3) more efficient safeguards against the spread of epidemic diseases; and (B) From an economic standpoint, as tending to prevent unnecessary interruption to travel and traffic during the existence of such diseases."

REPORT UPON THE OPERATIONS OF INSPECTION STATION NO. 2. BY F. W. PARHAM, M. D., INSPECTOR IN CHARGE.—"I have been requested from the office of the director to make a statement of my views concerning the inspection now closed. I will, perhaps, make myself clearer by prefacing my remarks by a brief description of the manner in which inspections have been performed at New Orleans and at this station.

"Having been assigned to duty at New Orleans for the months of June and July, and at President's Island (below Memphis) during August and September, I can speak from personal observation at both places.

"In New Orleans, boats were requested to notify us, as soon after arrival as possible, when it would be convenient for the inspector to make the necessary examinations. This time was generally after the cargo had been discharged and the rubbish removed from the hold and deck. The boat was examined throughout, from keelson to 'texas.' If her condition was found in all parts satisfactory, she was permitted to take on cargo; but if the bilge, hold, or other part inaccessible in a loaded boat was discovered in insanitary condition, directions were given for removing objectionable features, and a second visit was paid to ascertain what efforts had been made to carry out instructions before loading began. Finally, just before departure an examination was instituted, especially to determine the character and condition of cargo, to visit those portions of the boat not seen in the previous inspections, to see all sick persons on board, and to furnish the certificate filled out according to the facts.

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* See report National Board of Health, 1880, pages 618, 619, 620.

"(1) It should be stated that special attention was paid to the following articles of cargo: Coffee, sugar, fruits and other articles from tropical ports; second-hand bedding and clothing, rags and paper stock. The sanitary history of all shipments of the last four articles, namely, second-hand bedding and clothing, rags and paper stock, was carefully inquired into, and the information elicited was entered upon the certificate of inspection for the benefit of intermediate ports, as well as the port of destination. The publicity thus given led to the almost total abandonment of shipments of this dangerous character during the summer months.

"At this station (President's Island) the manner of proceeding was somewhat different. Boats from Vicksburg and above were treated as in New Orleans, excepting that only one inspection was required, all desired information being obtainable, owing to the fact that during the summer season these boats do not carry much freight in the holds. With reference to boats from New Orleans, if the New Orleans inspector had certified that the condition of boat, her cargo and passengers were entirely satisfactory, or if this not being the case, the inspector at Station No. 1 had endorsed on the certificate as the result of his examination that all objections of the New Orleans inspector had been removed, it was not considered necessary at this station (No. 2) to detain the boat so long as would be required to enable the inspector to make a thorough reinspection; but any changes in cargo and passengers since leaving last station were noted, all sick persons on board were personally examined, and the diagnosis stated in the form.

"If a boat had not an originally 'clean' bill nor a proper endorsement by last inspector. she was examined with reference to those points objected to by the last officer of the service, or, no matter what the certificate evidenced, if the boat was one whose officers had in any way betrayed a desire to cover up insanitary conditions, such search was made as was necessary to determine the actual facts, and the result was stated on her bill without alluding to the conduct of the officers. Thus the service has been carried on; the foundation principle that the power of the inspector was derived solely from the will of the people, as expressed through their State or local health authorities in demanding that boats should comply with the regulations of the National Board of Health, has been fully recognized, and nothing unreasonable has been asked and the smallest possible inconvenience and detention of boats have been entailed.

"A. PREVENTIVE MEDICINE; B. ECONOMY.—As a measure of preventive medicine this service has secured an improved condition of steamboats and barges. The parts of a boat most likely to accumulate dirt and filth and those to which naturally the least attention is generally paid are the bilge, the water closets (particularly those on lower deck, used by roustabouts), and the crew's quarters. The hold is generally cleaned out after unloading, but the bilge, with the exception of occasional pumpings, is only at long intervals thoroughly purified; the water closets for passengers are usually tolerably well cared for, but those used by the deck hands, being more indecently and frequently patronized, are very often found in very filthy state; the quarters for crews, especially those on main deck, are in many instances badly ventilated and kept closed for the most part of the day, furnished badly and unused to cleanliness, or, indeed, to decency.

"The practical benefits secured by the inspections are: (1) The attention of captains has been repeatedly called to these insanitary conditions and to the necessity of correcting them. (2) They have been told how this could be done, and (3) they have generally attempted some improvement and in many cases succeeded in satisfying the demands of the service. Second inspections have often revealed the turning up of the dunnage-boards for the removal of decomposing grain and other organic matters and mud, and the improvement of the odor of bilge-water by the (total or partial) substitution of fresh, with the addition of copperas; the cleansing of the water closets and their disinfection with copperas solution, lime-wash, or chloride of lime, the better ventilation of sleeping apartments, and greater attention to neatness.

"Sometimes boats remained in port so short a time that little could be accomplished before departure, and it was not deemed prudent to invite opposition by harshness or the attempt to enforce the execution of the measures advised. Under these circumstances the facts were stated on certificate and the captain requested to have the directions carried out as far as possible on the way up the river. This course had to be pursued with some steamboats and with many barges, and was found to work well. At this station, I have examined barges, certified to by inspectors below as in bad sanitary condition, in an advanced state of purification, and the progress of the work could in some instances be traced. It is true we have met with objections and refusals to comply with our regulations, but in the main an unexpected acquiescence has been experienced and the sanitary conditions of boats and barges has been improved. It may prove of interest to glance at the agencies that have brought about this desirable result.

"(1) Letters were early in the season addressed to the presiding officer of steamboat and transportation companies in Saint Louis, Cincinnati, and elsewhere, requesting them to issue such orders as would facilitate the work of the inspectors.

"In response to this request, written orders were sent to the different boats of the St. Louis and New Orleans Anchor Line, verbal instructions to the St. Louis and New Orleans Transportation Company (barges), and to others. These orders materially assisted the efforts of the inspectors, as they were generally carried out.

" (2) Letters were sent the New Orleans agents of barge lines requesting them to have their barges overhauled as thoroughly as possible and cleaned out in St. Louis, where the work could be better and more expeditiously accomplished. In complying with this request, the managers aided us by starting out the barges for the summer trade in much better condition than heretofore.

" (3) The spirit of rivalry among boats in matters of cleanliness was stimulated by the watchfulness of the service.

"(4) The fear of detention or of exclusion from certain landings, when no certificate had been obtained, also operated to effect the end in view.

"(5) The experience of the past called attention to the possible renewal of the establishment of onerous and hurtful quarantines, and the results of 1879 seemed to promise an avoidance of these evils for 1880, at the same time that the public health was more perfectly protected. The steamboat interest deemed it wise to foster a service moderate in its demands and approved by the people. I can offer no evidence that the service has secured "a heightened sense of public health responsibility among shippers and common carriers," save (1) a manifest desire to understand what was required; (2) the readiness in many cases compared with the unwillingness in others with which they complied with all the rules and regulations; and (3) the opinions pronounced by some interested in the *protection* of trade as to the necessity of imposing such *restraints* upon commerce as the preservation of the public health demanded. *Taken in connection with* (4) the high and *impartial* stand in the outset assumed by the National Board of Health, offering a hope that a middle course might be steered with safety between the protection of health and the destruction of business, *enlightened* the people and called a halt to the selfish tendencies of the business community.

"MORE EFFICIENT SAFEGUARDS AGAINST THE SPREAD OF EPIDEMIC DISEASES ALONG THE VALLEY.—"(C.) The *frequent* repetition of inspections diminishes the chances of transportation of infected persons or things by affording increased opportunities to detect what might have eluded the vigilance of preceding inspectors as to existence of articles of freight of doubtful nature, and to discover the development *in transitu* of contagious and infectious disease.

"The number of stations and the accessories there found provide for the better care and treatment of the sick, which shotgun quarantines recklessly ignore. The service provided for the employment of an extra physician and nurses to obtain these desirable ends. It also secures the more complete isolation of the *sick* from the *well* of the boats and from communities.

"Medical attendant and nurses are debarred communication with the station and the outside world (except under necessary restrictions), and are enjoined not only to keep vigilant watch over the condition of the sick, but also to restrain their movements within certain limits. The arrangements at Station No. 2 permit the accomplishment of this by means of a hospital fleet moored at a convenient but safe distance from the inspection station, and of hospital tents. Comfort and isolation can thus be obtained.

"The housing and care of the healthy or uncompromised among the passengers who are retained for observation and isolated until such time as it is deemed safe for them to proceed, are also amply provided for, as is likewise the efficient treatment of infected vessels.

"This station, situated near the southwestern extremity of President's Island, offers peculiar advantages for the objects above enumerated. Distinct from the mainland, distant ten miles from Memphis, and sparsely populated, furnished with all necessary appliances and conveniences, it is possible to accomplish the most satisfactory attainable isolation.

"At least fifty authentic cases of yellow fever occurred in the city of New Orleans in the summer and early fall of 1879, and the prejudiced even must admit that there was an unusual lack of absurd and onerous quarantines, which so often entail suffering and pecuniary loss, I think I do not go too far in asserting that part at least of this desirable result had its source in the disinterested efforts of the National Board of Health.

"Further, comparison of the amount of business transacted by river and rail in 1879 with that done in years preceding the inauguration of this service will demonstrate that the confidence of the people has been enlisted, and that hasty and ill-advised quarantines did not cause much interruption to business, though danger at one time (in 1879) undoubtedly threatened.

"The history of the circumstances connected with the arrival in New Orleans on July 6 (when all the conditions were favorable to the development of yellow fever) from Rio de Janeiro of the infected ship Excelsior will prove the same proposition for 1880. The action of the National Board of Health in promptly notifying constituted authorities, and the measures taken to prevent any spread of infection from New Orleans, together with the action of the local boards of health in menaced communities in cooperation with this service undoubtedly averted panic, established confidence and obtained exemption from disease without seriously hurting business.

"WORK PERFORMED.—During the season, as above—namely, from May 25 to October 15, inclusive, there were inspected 1514 vessels, with an aggregate capacity of 1,234,450 tons, and carrying 81,395 persons, including passengers, officers and crews,

"Special inspections of coffee shipments, 2612 by river and 2552 by rail, were also made at the port of New Orleans, where, also, 26 passenger and 525 freight trains were inspected; making a grand aggregate of 89,274 river and rail inspections by the service.

"THE FLOATING HOSPITAL.—Two reasons induced the director, soon after the opening of the inspection season, to recommend the purchase of small flatboats out of which to extemporize floating hospital-wards to be attached to the inspection stations. The first of these was the more perfect isolation which could be secured by the reception and treatment of cases of infectious and contagious diseases on such floats; the second was that their use overcame the only opposition met with in the location of the stations. The opposition was of a most pronounced character at every place except on President's Island, near Memphis, and was based on the natural fear of those living near the proposed sites of the stations that these would become centres of infection if yellow fever, for example, were there taken ashore for treatment.

"Three of these boats were procured and fitted up with accommodations for four patients, and two nurses each. One was assigned to each of the three stations, Bayou Sara, Vicksburg and Memphis. Those for the two former stations reached Vicksburg only a day or two before the arrival of the towboat Haven, and were at once used for the reception of her suspicious cases.

"While the only structures which could be obtained during the past season were objectionable in many respects—small, fragile, leaky—the result of the experiment is such as to demonstrate that floating hospital-wards suitably constructed, must hereafter be considered indispensable features of all properly-equipped inspection stations." (See Report National Board of Health, 1880, pp. 618, 619 and 620.)

REMARKS.—The Holt System of Maritime Sanitation went into operation June 10, 1885, and from that time not even a single death from yellow fever is to be found in the records.

But why is it there was practically no yellow fever in the city during 1880, 1881, 1882, 1883, 1884—*i. e.*, five consecutive years?

Is it because there was no intercourse with the tropical countries?

But the records of the Mississippi Quarantine Station show that 548 vessels arrived there from ports liable to yellow fever from 1880 to 1884, both included.

Is it luck? But upon looking over the records from 1817 to 1897, a period of eighty-one years, we find only one such series of several consecutive years practically without yellow fever. In 1861, no deaths; 1862, 2 deaths; 1863, 2 deaths; 1864, 6 deaths (in the fleet); 1865, 2 deaths. These years were the years of the War of Secession, when there was practically no intercourse.

By studying the records we find some years with one or two or three deaths. In 1823 there was one death; in 1826, 5 deaths; in 1831, 2 deaths; in 1836, 5 deaths; in 1840, 3 deaths; in 1845, 2 deaths; in 1868, 5 deaths; in 1869, 3 deaths; in 1874, 11 deaths; in 1879, 1 death. But we find in the records no series of several years with practically no fever, as from 1880 to 1884, both included, and from 1861 to 1865, both included.

Is it not reasonable and just to say that it was because sanitation, as crude and primitive as it was, had been practised with more care than heretofore?

CALENTURA VS. YELLOW FEVER.*

BY C. H. TEBAULT, JR., M. D., FORMERLY ASSISTANT SURGEON U. S. A., NEW ORLEANS.

The name "calentura" is applied by Cubans to a specific fever which the writer found to exist in Santiago de Cuba, and which caused such a scare among the American troops after the surrender of the above city.

The disease presents so many symptoms in common with yellow fever, that a severe case of calentura associated with jaundice may very easily be confounded with an ordinary case of yellow fever.

From the several charts, notes are given of individual cases treated in the Officers' Hospital, Santiago de Cuba, where the writer served as Commanding Officer.

Drawing an average from these charts and notes, we find this fever to be of two and a half days' duration, and in the majority of cases preceded by a morning chill. The initial temperature is usually quite high—103 deg. to 105 deg. F., and the pulse begins to fall much sooner than in yellow fever, and remains slow for a longer period.

Calentura differs most prominently from yellow fever as follows:

1. The initial temperature is higher.
2. Chill usually comes in the morning.
3. Pulse becomes slow earlier in the disease.
4. Prolonged debility rather than "calm" or collapse.
5. Gastric irritability very slight.
6. Jaundice less common.
7. Albumin absent, or in traces.
8. Liver increased in size.
9. No secondary infection.
10. Bleeding of nose common, but other hemorrhages rare.
11. Tendency of attack to recur every three or four months among foreigners, and once or twice a year among natives.
12. The ridiculous fatality.
13. The rapid spread of the disease.

The writer lays great stress upon the gastric symptoms, and upon the absence of albumin. He observes that a great source of difficulty in diagnosis is caused by the occurrence of both diseases at the same time in the community. Yellow fever often travels in the wake of the more active "calentura." Yellow fever, however, existed as a four-leafed clover in the patch, so rare was it as compared with calentura. The two diseases occurred side by side, and comparisons were made. As the plasmodiæ malariæ were found in almost every disease in Santiago, the writer could not class this disease as one of the forms of malarial remittent.

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*Abstract of paper read at Orleans Parish Medical Society, July 22, 1899.

There was an obscure outbreak of fever in Ocean Springs, New Orleans and elsewhere in '97. The physicians disagreed as to its nomenclature. It resembled yellow fever in some respects and differed from it in many—especially in the percentage of deaths. Query: Was this not calentura, accompanied by a generous sprinkling of true yellow fever in its path?

Clinical Reports.

ANCHYLOSTOMIASIS.*

BY C. H. TEBAULT, JR., M.D., NEW ORLEANS.

I present a case of anchylostomiasis with the patient in a convalescing condition. I deemed that this subject would be of interest, as the diagnosis of this disease in our midst is rare, and even when the disease exists it is liable, as the present case will show, to be confounded with pernicious anemia and malarial anemia, especially when the latter disease is a complication.

Anchylostomiasis is a grave anemia produced by the anchylostomum duodenale, a nematode 6 to 15 *m.m.* in length by 1 *m.m.* in breadth, which inhabits the upper jejunum in large quantities. Here they exercise their leech-like proclivities and generate multitudes of ova, which are easily distinguished from those of the trichocephalus dispar and ascaris lumbricoides in that this ovum is beautifully transparent and its capsule is delicate and smooth. It was discovered by Dubini in 1838.

The disease is essentially tropical, but the appearance of this case in our city would lead one to believe that close investigation of the obscure anemias we frequently meet with would divulge the presence of this insidious little blood-sucking parasite with its innumerable ova.

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* Read at the Orleans Parish Medical Society, July 22, 1899.

In giving the symptoms of this disease, I know of no better authority to quote than Manson, whose mosquito theory applied to the extra-corporeal development of the malarial parasite is perhaps well known to you all. To his work on "Tropical Diseases" I refer you for a detailed description of anchylostomiasis: "The prominent symptoms are those of progressive anemia, which is generally associated with dyspeptic troubles, but which in uncomplicated cases is not associated with wasting. One of the earliest symptoms of an extensive anchylostomum invasion is pain or uneasiness in the epigastrium. The appetite, sometimes defective, is more often ravenous, but its gratification gives rise to diarrhea of imperfectly digested food. Fever of an irregular, intermitting type is common. The mucous surfaces and the skin become pallid, the face is puffy, and the feet and ankles are edematous. All the subjective symptoms of anemia are felt, and hemic bruits can be heard over the heart and large blood vessels."

We shall now consider the case I present before you.

George Heckle, aged 15, of German parentage, was admitted into ward 15, Charity Hospital, May 3, 1899. Patient was born in this city, and has lived here continuously. His father died of heart disease; the other members of the family, with the exception of a sister and himself, are healthy. I saw his sister and found her debilitated from menorrhagia.

The patient first complained of illness one and a half years ago He lost his color, had pains over the epigastrium, lost his appetite, and gradually grew weaker. He suffered from paroxysmal spells of diarrhea, and at times the stools were slightly tinged with blood.

He was treated in the hospital and afterward on the outside for pernicious anemia, and malarial anemia respectively, but with no material benefit. At the time of his second admission into the hospital he came under my observation.

I found anemia extreme, the conjunctiva showing no signs of arterioles. The lips were blanched and the tongue swollen and pale; the hands and feet were edematous, as were the lungs. Temperature ranged between 100 and 101 deg. Fahr. There was a loud hemic bruit over the aortic valve; liver, slightly enlarged; spleen, normal; urine, light colored; sp. gr., 1008; no albumin.

Subjective symptoms of capricious appetite, gastric irritability and headache were obtained from him. He also said that he had frequent attacks of diarrhea, followed by constipation. The stools, at times, contained streaks of blood. The patient was troubled with vertigo and "eye specks." He is not emaciated, but on the contrary, the adipose tissue is well preserved.

Having quite recently seen many cases of this disease in the tropics, I recognized, even before I examined the stools, the case to be one of anchylostomiasis.

A blood count was made on May 8. To the *c. m. m.:* Red corpuscles, 2,500,000; white corpuscles, 30,000.

The blood was also found to contain plasmodiæ malariæ.

The specimen of feces contained the ova of the anchylostomum duodenale. The weight of the patient was 79 pounds.

He was put on preparatory tonic treatment for a few days. After this, thymol, grains x, was given three times a day, between meals, scrupulous care being taken to avoid alcoholics, which would dissolve the thymol and produce thymol poisoning. This was kept up for two days, and at the end of that time a large dose of castor oil was administered.

After a rest of four days, ʒi extract of male fern was prescribed, followed by oil. The evacuations contained numerous anchylostomes. The patient was now put on arsenauro and compound syr. hypophosphites.

The appetite began to return and the headache to disappear.

May 25. Blood count, to the *c.m m.:* Red corpuscles, 3,400,000; white corpuscles, 30,000.

May 28. The dose of male fern was repeated. From now on the patient's appetite became ravenous; the conjunctivæ displayed arterioles and the lips and tongue took a more natural hue.

June 5. Blood count, to the *c.m.m.:* Red corpuscles, 4,270,000; white corpuscles, 30,000.

The temperature, which formerly held a steady course, as above mentioned, became normal. The patient's weight has increased to 85 pounds. The cardiac bruits have ceased, and edema of extremities has long since disappeared.

There are no more ova or anchylostomes in the feces, and the patient is able to do active work without unusual fatigue.

A blood count was finally made on July 12. To the *c.m.m.:* Red corpuscles, 5,540,000; white corpuscles, 30,000.

I extend acknowledgments to Mr. Thomas, resident student of Charity Hospital, for the records of this case and to the pathologic department of the hospital for its valuable assistance.

A CASE OF DIABETES MELLITUS.

BY P. L. CUSACHS, M. D., VISITING PHYSICIAN TO CHARITY HOSPITAL, NEW ORLEANS.

Y. G. Admitted in my ward at the Charity Hospital, on the twentieth day of last month.

Patient is by occupation a clerk. He has spent all his life in Louisiana. His father died during the civil war, cause unknown. He is similarly in ignorance as to what produced his mother's death.

About four months ago he contracted a cold. He also gives a previous history of gonorrhea.

At present the diagnosis is diabetes mellitus, cirrhosis of the liver and probable phthisis pulmonalis,* although no bacilli were found in the sputum after two examinations. At about the time that he caught the cold that he speaks of, he became very thirsty, always craving for cold drinks. His bowels became constipated frequently. He felt a continual desire to urinate, and many a time he did have to get up at night for that purpose. The urine was discharged freely, with a burning feeling.

His appetite is good, but he has lost much flesh and strength. A month ago he had pains in the calves and swollen and eczematous feet. His feet, moreover, sweated profusely. The tongue is large, flabby and covered with little papules that caused much itching. He also complains of a sensation of weight in the epigastrium.

The temperature is generally subnormal, about 97 deg. Fahrenheit. At the right apex, auscultation reveals mucous râles; and at the left, mucous and subcrepitant râles. The heart is normal and so is the spleen. The liver is sclerotic and there is some ascites, plainly demonstrated by percussing the patient while he reclines on the right side.

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*Since case was reported at Orleans Parish Medical Society, July 22, tubercle bacilli have been found in sputum.

The origin of diabetes mellitus, as we all know, is very much discussed and theorized upon. Very often it is impossible to find a satisfactory cause for that interesting disease. In this case it is my opinion that the cirrhosis of the liver has by pressure or in some other way impaired its glycogenic function, glycosuria being an immediate result of the decomposition of the carbohydrates. Perhaps there is some necrosis; perhaps some disease of the pancreas; unfortunately only a post-mortem examination can determine lesions there. He gives no history, not even of malaria; he confesses that he indulged in liquors, although not excessively, and that he smoked a great deal.

Mr. Granger, resident student of the New Orleans Charity Hospital, and I kept a record of the urine passed daily by the patient, and frequently had the same analyzed quantitatively. Here is the result of those examinations:

On June 20, J. G. passed ten pints and a half of urine.

On June 27, he passed seven pints and four ounces, which gave 145 grams glucose.

On June 30, he passed four and a half pints, which gave 112 grams glucose.

On July 2, he passed four pints and one ounce, which gave 203 grams glucose.

That large amount of sugar was due to the patient's own fault Some friends to whom he had complained about the strict animal diet to which he was subjected had brought him a few carbohydrates, which, of course, he ate. Afterward he was strictly watched.

On July 4, he passed 3 pints 9 ounces urine with 89 grams glucose.

On July 5, he passed 3 pints 9 ounces urine with ½ grain to 8 drops, 89 grams glucose.

On July 8, he passed 4 pints 3 ounces urine with ½ grain to 8 drops, 103.7 grams glucose.

On July 10, he passed 4 pints 4 ounces urine with 0.025 to 6 drops, 90.7 grams glucose.

On July 12, he passed 4 pints 10 ounces urine with 0.025 to 9 drops, 98.6 grams glucose.

On July 14, he passed 8 pints urine with 0.025 to 11 drops, 139.6 grams glucose.

On July 17, he passed 5 pints 6 ounces urine with 0.025 to 6 drops, 172 grams glucose.

On July 19, he passed 6 pints 4 ounces urine with 0.025 to 6½ drops, 184.6 grams glucose.

Treatment.—During several weeks, until July the 12th, I gave to the patient essence pancreaticus, one tablespoonful three times daily, on the principle that the pancreatic juice is diminished and impoverished by tuberculosis. As a tonic, strychnin, guaiacol and digitalis mixture. Of course, a strict animal diet was enforced from the very first day; saccharin instead of sugar in his coffee.

The result of that treatment was poor, for J. G. kept on passing from three to five ounces of glucose daily; then, as an experiment, I administered aromatic sulphuric acid.

On July the 13th I decided to treat him with arsenauro, beginning with five drops three times daily, and adding one drop at each dose. I can not say that I have yet obtained a wonderful success from the much boasted of arsenauro. The young man becomes weaker every day, and I am intending to treat him for his cirrhosis rather than for his glycosuria, if no improvement is manifested soon. Warm applications and diuretics might do him still much good, although the prognosis is unfortunately exceedingly grave.

A CASE OF STRANGULATED INGUINAL HERNIA IN A FIVE-MONTHS-OLD BABY—OPERATION—RECOVERY.

By E. D. Fenner, M. D., First Assistant Surgeon, Charity Hospital; Lecturer on Diseases of Children, Medical Department, Tulane University, New Orleans.

Lionel Kharton, five months old, breast fed, had always been healthy and well until March 27, when he began straining and vomiting. At the same time the mother noticed that a lump in the right inguinal region, which she had first discovered when the baby was four weeks old, was large and tense, and could no longer be pushed back as she had formerly been able to do with ease. On March 29 the vomiting continuing, and having become fecal in character, she brought the child to the hospital. On admission the baby was considerably depressed, and presented a large right inguinal hernia. Taxis was tried without success, when chloroform was administered and renewed efforts at reduction were made. These efforts did not succeed and an operation was recommended, but had to be postponed because the mother said she must first see her husband and get his consent.

In the afternoon she returned with the desired permission, and the child having been properly prepared under chloroform anesthesia, the hernial sac was exposed and opened. The hernia was found to consist of the cecum, appendix and several inches of the adjoining ileum, together with a part of the omentum. The sac contained a considerable quantity of bloody fluid, and the bowel gave evidence of damage by strangulation. After considerable difficulty the internal ring was dilated with the finger tip and the bowels replaced. A ligature was passed around the neck of the sac, the cord being carefully excluded, and the incision in the skin rapidly sutured. This abandonment of a radical cure by the method of Bassini was due to the marked prostration of the little patient, who appeared to be almost at the point of death. To have attempted to clear the sac of this congenital hernia from the cord, and carry out the other steps of the Bassini operation would have been to sacrifice the patient to the method. I decided to save the patient; I had no desire to see him die cured.

Sent to the ward with a temperature of 101.5 deg., the baby rapidly reacted. The bowels moved twice the same evening. The mother was permitted to nurse the baby, and twenty drops of Ducro's Elixir were given every two hours.

During the following days the child rested well, nursed regularly and had about two movements of the bowels a day. Temperature meanwhile was slightly elevated, 101 deg. to 101.5 deg., and on April 1 there was some abdominal distention and a failure of the bowels to act. Thirty minims of castor oil, followed by an enema of soapsuds, relieved the condition, and thereafter there was no trouble.

The wound healed without suppuration, and on April 4 the child was discharged well.

In July the child is still well, but gives evidence of a partial return of the hernia, for which a truss was ordered.

PARAPHIMOSIS FROM A "GAGE D'AMOUR."

REPORTED BY DR. E. D. FENNER, M. D., NEW ORLEANS.

On June 27 there applied to the Charity Hospital for treatment a German, about 45 years of age. His disorder in its origin was venereal. Upon examination he presented a severe paraphimosis. The constricting band, however, was not cuticular, but was a brass ferrule, three-quarters of an inch wide, one-eighth of an inch thick and three-quarters of an inch inside diameter.

Shame and the fear of ridicule had kept this man silent for four days, until the pain, swelling and ulceration of the skin at last forced him to apply for relief.

He now confessed that his sweetheart, who, it was suggested, "must have had a lot of brass," had slipped the ferrule on him in his sleep, and when he awoke there was no escape from the clasp of this strange "*gage d'amour.*"

With a stout file, a pair of pliers and half an hour of steady work I succeeded in cutting through the ring, which was then sprung open with difficulty by the use of two heavy gas fitters' pliers. No words can adequately describe the ineffable expression that irradiated the victim's countenance when he found himself finally freed from its clasp. He was sent to a ward, but promptly deserted to escape the inevitable storm of ridicule that awaited him from the other patients.

Lecture.

THF PHYSICAL AND PHYSIOLOGIC PECULIARITIES OF THE CHILD.

Specially reported for the JOURNAL from a clinical lecture by Dr. E. P. Davis, at the Woman's Hospital, Philadelphia.

I wish to speak to-day of the physical and physiologic peculiarities of the child.

First, the face of the child is relatively small in proportion to its cranium. The brain mass is proportionally very large in the child. Recall from your study of embryology that the rudiments of this part are among the first things to appear. I recall the composition of a young school boy, who in his examination was trying to define a skeleton. He said: "A skeleton is a mass of bones held together with wires. On top of this is a box of bones called the skull, which contains the brains when there is any." Why is it so large? Because the infant is brought into life ready for the reception of impressions. The little child is simply a mass of sensitized matter upon which impressions are streaming in through all its senses. It is so much larger comparatively than in the adult; for as in the adult there are two parts skull to one part face, in the infant there are eight parts skull to one part face.

Another peculiar thing in the child is that the dura is adherent to the cranium. You must remember this; because the old-fashioned complaint of which children used to die was meningitis, or congestion of the brain. Inflammation of the brain was the old diagnosis when children died from pneumonia, or gastro-enteric or other affections. They saw the nervous manifestations. Very few children die of meningitis. In a great many autopsies of children very few have shown meningitis. It was the cerebral symptoms, simply indicating what was going on, not a distinct inflammation or change in the membranes.

We will pass now to consider the physiology of the lymphoid tissue of the pharynx. As we come to the pharynx we notice the abundance of the lymphoid material. First are the tonsils, two glands that are very large and so situated that the air must pass in some relation to them, and also all the food and drink. They are bodies whose function is not definitely known; they are often diseased. What is the true physiologic bearing of those on the body? When you are called upon to treat a child with sore throat, you go and find it has enlargement of the tonsils. If this does not subside in about two weeks, you send the child to a surgeon to have the tonsils removed. Then the mother comes to you and says the surgeon wants to take out the whole of the glands; and she has heard of cases where only parts of the glands have been removed, and she asks you if it is necessary to have the whole removed. Dr. Butler is associated with two throat specialists, who follow exactly opposite plans. One takes out all that can be taken out; the other does not take out the whole gland, but carefully treats the crypts and builds up the general condition of the patient, and then takes out enough of the gland to allow a free passage of air. And then a third will take out none at all if it can be helped. Now, which one of these is the correct view? So far as one can tell, each of these three has an argument in his favor; but on general principles I should adopt the middle view, and I think that is the one which should probably obtain in the greater number of cases.

What is the function of these glands? It is practically impossible to say. But in the first place we know that those children who inherit rheumatic and gouty tendencies have tonsillitis. When that is the case it clearly requires attention to the diet and secretions. The second class is infective and local. You may have occurrence of infection from the staphylococci and the streptococci. The crypts fill up with a muco-pus, and then get well after a few days. Then we have the more virulent form.

We will proceed next to the physiologic peculiarities of the chest. The heart of the child is large in comparison with that of an adult, and it is less covered with lung. The thymus gland and the heart together will occupy one-third of the chest cavity. I want to warn you against heart murmurs in children; they are transitory. The pulse is different when you come to study it. Up to six months a baby's pulse is from 120 to 130, respiration from forty to fifty. Between six and twelve months, the pulse drops only one or two, and the respiration drops ten. From twelve to eighteen months, the pulse drops to 110 and 120, while the respiration remains about the same. Then from eighteen to thirty months the pulse drops nearly to 100, and the respiration is twenty-five to thirty.

If you excite the child, or if it is excited by disease, the respiration will go up to eighty, while the pulse in disease may go up to 180 and 200, if you can count it. I have had the best nurses report that they could not count a child's pulse, it beat so rapidly. On the 19th of February one child that I saw had a respiration of eighty, a pulse of 165 and temperature of 106 deg. The child is living now, and stands a good chance for recovery.

What is the type of breathing in the child?

In all warm-blooded animals the type is mid-breathing—that is, neither abdominal nor thoracic. And this is so in the child. The subsequent difference of breathing in the two sexes is influenced by the difference of clothing. If you wish to look into this subject, you will find a mass of investigation by Harvard

University and other such schools. In disease the type of breathing is distinctly altered. So much for the physical and physiologic peculiarities of the chest.

Now let us look at the abdomen. I will first revert to the great size of the liver. One-eighth of the body weight of the infant is liver. The saying is that we are made of "back, brains and belly;" there is something in that. Then you know the old saying that life is worth the living in proportion to the size of the liver. The liver is the bank with which nature sends the child into the world, and there are enough blood cells in it to keep the child living until the grandmother stops worrying about its food.

The stomach is very unimportant. Stomachs have been entirely removed by operation; at any rate, the stomach is not what it used to be cracked up to be. In the baby it is an inconvenient little bottle, apt to spill over on any occasion. It is a sort of "cave of the winds." How much does it hold? This is hard to answer. The stomach is distensible. But it holds not more than an ounce when first born. Yet the child is expected to swallow about four ounces every two or three hours At ten months the stomach will hold eight ounces without stretching. How is all the food managed, then, in nursing? The child always takes more than it can assimilate, and then it always returns some. The stomach in a little child is different in position from that of an adult. It is more vertical. It is simply a coagulating bottle acting by a rennet ferment which it contains. It is an unimportant part in the child's body.

The bowels are a curious little trap to catch and retain the milk that comes until it is digested. They are hung low in the belly, and they move freely. The duodenum is literally a trap. The intestines are rudimentary in the development of glandular structure. The kidneys are normal, except that there is the presence of uric acid in a large majority of cases. They are subsequently flushed out and this disappears.

The whole process of digestion in a child is radically different. The first important act is sucking, and this is useful as a diagnostic sign. If the child can suck without dropping the nipple, then there is no serious occlusion of the respiratory tract. The saliva is not present until the third or fourth month, and then it increases as the teeth come in. If there is no saliva in little children, then, for the digestion of starch shall starchy food be given to them? The stomach is, as I have said, a coagulatory body; it converts proteids into acid albumins, albumoses and peptones. There is pepsin in the stomach of the child, but the larger portion of the ferment is rennet. After a meal of milk the reaction of the stomach is distinctly alkaline. After a meal of cows' milk it is acid. This shows the chemical difference between the mother's milk and cows' milk; the normal digestion is interfered with when there is this difference. The acid albumins and albumoses are formed from proteids in ten or fifteen minutes, and they are rapidly absorbed. In most children the stomach is quite empty in thirty minutes after nursing. In review then, the stomach is a coagulating bottle from which absorption goes on very rapidly. It contains a ferment rennet, which acts on proteids and not on fats.

We come now to consider intestinal digestion, the really important part of the child's digestion. The digestion is largely pancreatic, undoubtedly. Proteids, carbohydrates and fats are broken up in this digestion, and for six months after birth there is scarcely any ferment in the converting of starch into other materials. Sugars are broken up.

We now come to the liver. It furnishes an abundant secretion of bile, which acts as a lubricant and greatly assists in the breaking up of fats.

The digestion in the child differs from that of an adult, then, principally in these things, the trivial part which the stomach plays, and the lengthened digestion of the bowels; the fact of the great importance of the pancreas — the one digestive organ of paramount importance, and then the alkaline media of the intestines are favorable to pancreatic digestion.

Now if all of these facts are true, what class of foods is it safe to give the child? Shall we give starch? No. Shall we give proteids? Yes, and fats and sugars. Why? Because the child is made that way. There are artificial foods that are made of starch, or of starch largely converted, and these foods are largely successful. But they are successful because they are made to sell, and they do sell. Whether they are adapted for infant feeding is another matter.

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The medical profession of Indianapolis will tender a reception to the association on Tuesday evening at 9 o'clock, which Fellows and guests are expected to attend.

A committee of arrangements has been organized, consisting of a number of physicians of Indianapolis, under the chairmanship of Dr. L. H. Dunning, which is working assiduously for the success of the meeting.

All members of the medical profession are cordially invited to attend the scientific sessions, for which a very interesting preliminary program has been arranged.

PARTICULAR.—The Grocer: "Yes, sir; this grano-grino is the best breakfast food on the market. It is predigested—" Mr. Fadsby (shuddering): "Bless my soul! By whom?"—*Ex.*

THE JEFFERSON MEDICAL COLLEGE has issued invitations for the opening exercises of its new buildings and laboratories on October 2, 1899.

A HOME for lepers was officially opened on August, 1899, at Memel, East Prussia, being the first establishment of this kind near the Russian frontier. It has already been well filled with patients.

DR. EVERETT E. ELLIS, Dyersburg, Tenn., formerly a resident student at Charity Hospital, has moved to Hot Springs, Arkansas.

HEAVEN ENOUGH.—An editor who died of starvation, was being escorted to heaven by an angel who had been sent out for that purpose.

"May I look at the other place before we ascend to eternal happiness?"

''Easily,'' said the angel.

So they went below and took in the sights. The angel lost track of the editor, and after a time found him sitting by a furnace fanning himself and gazing with rapture upon a lot of people inside.

''Come,'' said the angel, '' we must be going.''

''You go on,'' said the editor, and, as he pointed to a sign ''Delinquent Subscribers,'' ''I'm not coming. This is heaven enough for me.''

Obituary.

DR. J. N. CHARBONNET, a prominent young physician of New Orleans, died July 22, 1899. Dr. Charbonnet had served as a resident student at Charity Hospital, graduating in medicine from Tulane in 1887.

The deceased was well known and well liked by the profession and laity alike.

The following resolutions were adopted by the Orleans Parish Medical Society, August 26, 1899:

WHEREAS, The ruthless hand of death has drawn from our midst one of the most promising young members of the medical profession in the person of Dr. J. N. Charbonnet;

Be it Resolved, That the Orleans Parish Medical Society, the profession and the public have sustained a very great loss in his untimely end, being taken away just at a time when he was beginning to reap the results of many years of studious attention to his profession. Always kind and gentle, never tiring in his ministrations to suffering humanity, he had endeared himself to a very large clientele.

Resolved, That we tender to the grief-stricken family our deepest sympathy in the loss they have sustained, and trust that time will temper even the sting of death and that He who overlooks all our destinies may comfort them in their great affliction.

Resolved, That these resolutions be spread upon the minutes of the society and a copy be sent to the family of our deceasd brother.

Committee { M. J. MAGRUDER, M. D., *Chairman*,
L. G. LEBEUF, M. D.

Dr. Edward T. Shepard died August 15, 1899, at the age of 56 years.

Dr. Shepard has been identified with the medical profession of New Orleans for over thirty years.

He lived in touch with the light of the profession and was full of anecdote of the men of his quarter of a century. Such men as Holliday, Crawcour and the elder Bemiss were confrères and older brothers.

Dr. Shepard has left behind him the attachment of more patients than most men who practice medicine here.

Dr. Shepard was born in Cincinnati, spending his early life in Connecticut and Texas. He served as a hospital steward on the Confederate side during the Civil war.

He graduated from the Charity Hospital in 1867; then he went abroad and studied some time in Vienna. His career as a practitioner was eminently a success. For many years prior to his death he was connected with the Louisiana Retreat for the insane, with the Asylum of the Little Sisters of the Poor, and other charitable and benevolent institutions. He was at one time administrator of Charity Hospital. Dr. Shepard was a member of several social clubs, and he was always interested in medical and social gatherings.

He was always approachable, but painfully modest at times. His sensitive disposition made and lost friendships for him.

The supremest thing which might be said of him was that he was a domestic man above all things, and that his home was the expression of the best in him—devotion to those he loved.

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Resolved, That in the death of our brother we have lost a member most highly esteemed for his professional attainments and for his ever pleasant social relations with his fellows, and that in consequence of his large clientele, successful practice and most charitable disposition, the public have sustained an irreparable loss.

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A GOOD IDEA.—Dr. Lajoie, an American physician domiciled in Paris, has established a bureau of information, at 21 Rue de l'École, for American physicians visiting that metropolis for the purpose of study.

THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS will hold its twelfth annual meeting in the assembly room of the Denison House, Indianapolis, Ind., Tuesday, Wednesday and Thursday, September 19, 20 and 21, 1899.

The medical profession of Indianapolis will tender a reception to the association on Tuesday evening at 9 o'clock, which Fellows and guests are expected to attend.

A committee of arrangements has been organized, consisting of a number of physicians of Indianapolis, under the chairmanship of Dr. L. H. Dunning, which is working assiduously for the success of the meeting.

All members of the medical profession are cordially invited to attend the scientific sessions, for which a very interesting preliminary program has been arranged.

PARTICULAR.—The Grocer: "Yes, sir; this grano-grino is the best breakfast food on the market. It is predigested—" Mr. Fadsby (shuddering): "Bless my soul! By whom?"—*Ex.*

THE JEFFERSON MEDICAL COLLEGE has issued invitations for the opening exercises of its new buildings and laboratories on October 2, 1899.

A HOME for lepers was officially opened on August, 1899, at Memel, East Prussia, being the first establishment of this kind near the Russian frontier. It has already been well filled with patients.

DR. EVERETT E. ELLIS, Dyersburg, Tenn., formerly a resident student at Charity Hospital, has moved to Hot Springs, Arkansas.

HEAVEN ENOUGH.—An editor who died of starvation, was being escorted to heaven by an angel who had been sent out for that purpose.

"May I look at the other place before we ascend to eternal happiness?"

"Easily," said the angel.

So they went below and took in the sights. The angel lost track of the editor, and after a time found him sitting by a furnace fanning himself and gazing with rapture upon a lot of people inside.

"Come," said the angel, " we must be going."

"You go on," said the editor, and, as he pointed to a sign "Delinquent Subscribers," "I'm not coming. This is heaven enough for me."

Obituary.

Dr. J. N. Charbonnet, a prominent young physician of New Orleans, died July 22, 1899. Dr. Charbonnet had served as a resident student at Charity Hospital, graduating in medicine from Tulane in 1887.

The deceased was well known and well liked by the profession and laity alike.

The following resolutions were adopted by the Orleans Parish Medical Society, August 26, 1899:

Whereas, The ruthless hand of death has drawn from our midst one of the most promising young members of the medical profession in the person of Dr. J. N. Charbonnet;

Be it Resolved, That the Orleans Parish Medical Society, the profession and the public have sustained a very great loss in his untimely end, being taken away just at a time when he was beginning to reap the results of many years of studious attention to his profession. Always kind and gentle, never tiring in his ministrations to suffering humanity, he had endeared himself to a very large clientele.

Resolved, That we tender to the grief-stricken family our deepest sympathy in the loss they have sustained, and trust that time will temper even the sting of death and that He who overlooks all our destinies may comfort them in their great affliction.

Resolved, That these resolutions be spread upon the minutes of the society and a copy be sent to the family of our deceasd brother.

Committee { M. J. Magruder, M. D., *Chairman*,
L. G. LeBeuf, M. D.

Dr. Edward T. Shepard died August 15, 1899, at the age of 56 years.

Dr. Shepard has been identified with the medical profession of New Orleans for over thirty years.

He lived in touch with the light of the profession and was full of anecdote of the men of his quarter of a century. Such men as Holliday, Crawcour and the elder Bemiss were confrères and older brothers.

Dr. Shepard has left behind him the attachment of more patients than most men who practice medicine here.

Dr. Shepard was born in Cincinnati, spending his early life in Connecticut and Texas. He served as a hospital steward on the Confederate side during the Civil war.

He graduated from the Charity Hospital in 1867; then he went abroad and studied some time in Vienna. His career as a practitioner was eminently a success. For many years prior to his death he was connected with the Louisiana Retreat for the insane, with the Asylum of the Little Sisters of the Poor, and other charitable and benevolent institutions. He was at one time administrator of Charity Hospital. Dr. Shepard was a member of several social clubs, and he was always interested in medical and social gatherings.

He was always approachable, but painfully modest at times. His sensitive disposition made and lost friendships for him.

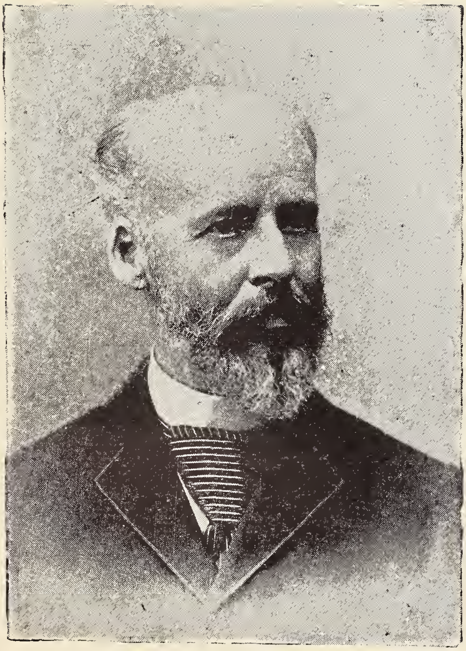
The supremest thing which might be said of him was that he was a domestic man above all things, and that his home was the expression of the best in him—devotion to those he loved.

The following resolutions were adopted by the Orleans Parish Medical Society August 26, 1899:

We, the undersigned members of the committee appointed to draft resolutions on the death of Dr. E. T. Shepard, beg to report and advise the adoption of the following resolutions:

Whereas, in the course of the eventualities of Nature Dr. E. T. Shepard, a member of the Orleans Parish Medical Society, has been suddenly removed from this sphere of action;

Resolved, That in the death of our brother we have lost a member most highly esteemed for his professional attainments and for his ever pleasant social relations with his fellows, and that in consequence of his large clientele, successful practice and most charitable disposition, the public have sustained an irreparable loss.



DR. EDWARD TAYLOR SHEPARD.

DECEASED.

Resolved, That to his large and affectionate family we hereby tender our most sincere condolence in this their great sorrow, hoping that they will bear the same with philosophic and Christian resignation, comforted with a reflection on his well spent life and an innate hope of a reunion where troubles and sorrow have no place.

Resolved, That these resolutions be spread on the minutes of this society, published in the New Orleans MEDICAL AND SURGICAL JOURNAL, and a copy be transmitted to the family of the deceased.

Committee { A. PETTIT, M. D., *Chairman*,
F. A. LARUE, M. D.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of DR. F. W. PARHAM, assisted by DR. F. LARUE, New Orleans.

ENLARGEMENT OF THE SPHERE OF LOCAL ANESTHESIA.—The recent article of August Bier, of Kiel (Versuche ueber Cocainisirung des Rückenmarkes, *Deutsche Zeitschrift für Chirurgie*, April, 1899), has again brought the subject of anesthesia by the spinal route prominently before the profession. We wish in no manner to detract from the merit of the observations and investigations of Bier as brought out in this paper, but the matter is of such importance in surgery that we desire to call the attention of our readers not only to this work of Bier, but also to the previous experiments of J. Leonard Corning, of New York, whose observations are entirely ignored. It is perhaps better first to give a brief *résumé* of the article of Bier and afterward to show how much of his conclusions had been anticipated and established by Corning.

Under Schleich anesthesia the lumbar puncture of Quincke is carried out. A very small hollow needle closed with a stopper is inserted, when the stopper is removed and the finger placed over the end to prevent the escape of cerebro-spinal fluid. A Pravaz syringe, carrying a needle which exactly fits the lumen of the canula, is then introduced and the desired amount of cocain solution thrown into the spinal canal, a calculation being made of the amount still remaining in the needle. The whole apparatus is left in place for about two minutes in order to prevent the soaking of the solution from the puncture canal into the surrounding tissues.

The following observations are reported by Bier:

I. A laborer, 34 years of age, suffering from hopeless tuberculosis of numerous parts of the body, had to undergo a resection of the ankle-joint to palliate the great pain and high fever. August 16, 1898, 3 *c.c.m.* of 0.5 per cent. solution of cocain were injected, in all 0.015 g. In twenty minutes the sensation of the lower half of the body was abolished, even the sense of touch. Pricking, pinching and other painful manipulations were felt only as pressure. The resection was carried out, and though the patient complained during the operation, he said afterward he had had no pain, but was merely conscious that something was being done to the foot.

The pulse was somewhat accelerated during the operation, but otherwise unaffected. Two hours after the operation, pain in the region of the sacrum and in the leg appeared along with vomiting and severe pains in the head. The pain in the leg and the vomiting gradually subsided, but the head pains continued into the following day.

II. A 17-year-old baker, suffering from an osteomyelitic necrosis of the tibia, received on August 20, 1898, at the first injection, ½ *c.c.m.* of a 1 per cent. solution, and two minutes later ½ *c.c.m.* more (altogether 0.01g.). In five minutes the sensation of pain was entirely abolished, but not touch. The operation, begun six minutes after the second injection, lasted fifteen minutes. Not the slightest pain was felt. Nearly the whole diaphysis of the tibia was chiseled out and several sequestra removed. Vomiting began fifteen minutes after the last injection. Twenty-five minutes after the last injection the sensibility was examined. This was completely abolished on the right side up to the eighth rib in front, and ninth rib behind; on the left side to the fifth rib in front and to the eighth rib behind, neither needle-pricking nor contact being felt. The sensation began to return thirty-nine minutes after the last injection.

About two hours after the operation violent headache and later twice vomiting. The headache continued from time to time for two days, and again manifested itself on the sixth and eighth days thereafter, and on the eighth day there was vomiting. After this he was well.

III. A 14-year-old boy suffering from ankylosis of the knee-joint from old tuberculosis. August 20, 1898, an injection of cocain was made, and two minutes later a second, in all 0.01g. cocain, and Helferich's resection of the knee was done and the bones held together with three nails. The boy complained the whole time, but it was evident from the absence of any attempt to prevent the manipulations that there was no pain. On the following day there was pain in the back and leg, which continued for seven days. Six days after the operation headache showed itself, but otherwise there was no disturbance.

IV. An 11-year-old boy with tuberculous disease of the ischial tuberosity. He got 0.005g. cocain. In seven minutes sensation was abolished. Two minutes later operation begun and finished rapidly. Anesthesia satisfactory. Twenty-five minutes after the injection sensibility of the whole body, with the exception of the head, was abolished; even on the arm and neck there was no sensation of pain. There was no subsequent headache nor vomiting, the lad complaining only of the puncture where the cocain was introduced.

V. A 30-year-old man suffering of a compound fracture of the right thigh, which had suppurated. August 24, 1898, 00.1 g. cocain was injected, and 12 minutes later a long incision was made on the outer side of the thigh, the diseased bone discovered and sawed off, and the wound tamponed after evacuation of numerous pus sacs. Notwithstanding the violent manipulations required to bring the femur out of the wound, there was no pain at all, neither during nor after the operation, with the exception of a slight headache, which very quickly disappeared.

VI. A 17-year-old girl, suffering of an acute osteomyelitis of the back part of the left femur. August 27, 1898, 0.005 g. cocain was injected, and twenty minutes later the operation was begun. She whimpered during the operation, but declared afterwards that she had suffered no pain at all. There were no untoward effects either during or after the operation.

These cases show that even major operations may be done under the influence of extremely small doses of cocain, but they show also that certain disagreeable effects, observed in the majority of cases, attend the carrying out of the method.

Bier next undertook the experiment on himself, but failed to get the expected anesthesia, although the disagreeable effects were quite marked. His failure was undoubtedly due to the faulty technic, whereby the cerebro-spinal fluid was allowed to escape, and along with it the cocain injected.

Subsequently Hildebrand permitted the experiment to be carried out on him; 0.005 g. cocain was injected. The experiment was eminently successful as to the abolition of pain, but the disagreeable effects were pronounced and persistent for some days, probably owing to the fact that Hilebrand attempted to go about his duties as usual. Whenever he was horizontal, the symptoms all disappeared. This much is to be said, that after all major operations, the recumbency in bed would probably do away with many of the untoward effects. The general conclusion, we think, may be drawn from these experiments, that in any case requiring major operation, the patient's condition not justifying a general anesthetic, this method may be carried out.

To whom does the priority for this great discovery belong? Undoubtedly to an American, J. Leonard Corning, of New York. In Corning's book on Local Anesthesia, written in 1885 and published in 1886, he clearly sets forth the method of anesthesia by injection between the spinous processes, although it must be said that he did not inject the cocain into the canal, but only into the subcutaneous space, to be there taken up by the veins and by them carried into the canal. The effects were decided, but very much larger quantities of cocain were used than in Bier's method. In his second experiment, which was done on a man, 30 minims of 3 per cent. solution were injected between the eleventh and twelfth dorsal vertebræ. Numbness was experienced ten minutes later, and twenty minutes later the tests showed the sensation impaired to marked degree. The patellar tendon reflex was abolished.

Again, as pointed out in a recent editorial in the *Medical Record*, Corning brought the method to the notice of the profession in 1888. In an article entitled "Further Contributions on the Local Medication of the Spinal Cord," published in the

Medical Record, March 17, 1888, the researches were greatly extended and elaborated, and in his book on "Pain," published in 1894, he describes a method by which the anesthetic is deposited within the membranous coverings of the spinal cord. This latter publication would seem to fix the claim with Corning, but to Bier belongs the credit of thoroughly establishing the method on a surgical basis, although we do not clearly understand why he fails properly to credit Corning with the first theoretic and practical demonstration of the method. It would seem reasonable and just to both that the procedure should be called the Bier-Corning Method of Spinal Anesthesia. The infinitesimal amounts of cocain used by Bier strike one very forcibly. Surely, the untoward effects can not be due to the drug itself; the case of Bier himself, where the small quantity injected ran out with the spinal fluid, would also negative this. It must be due to the introduction of a strange fluid into the canal on the delicate nerve structure. Perhaps the use of eucain beta (which, moreover, can be sterilized), dissolved in Schleich's salt solution (which Bier does not mention), would be less irritating; and then care in preventing escape of the spinal fluid (without doubt a cause in some of the cases) would much minimize the danger of irritation effects.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER,
New Orleans, La.

A CONVENIENT TECHNIC FOR THE DELIVERY OF THE AFTER-COMING HEAD WHERE GROSS DISPROPORTION EXISTS is suggested by Dr. Frank A. Stahl in the *American Journal of Obstetrics* for April, 1899. In a case of marked hydrocephalus, where the child had presented by the breech, the head was amputated after the body was expelled, the head then brought into a suitable position for perforation and easily disposed of. The question arises as to the applicability of such a procedure in an instance of normal fetal head and gross pelvic contraction. Stahl would adopt this technic in such cases, believing that it leaves nothing to be wished for. All the recognized methods for the disposition of the after-coming head present the same principles: Perforation of the base of the skull, excerebration through the canal of perforation, extraction; if necessary, craniotomy or basiotripsy. After a thorough review of all the methods advanced, Stahl concludes with a quotation from Cameron (*Amer. Text-Book of Obstet.*), who writes of craniotomy of the after-coming head: "This is always a difficult operation, since the trunk interferes with the necessary manipulations. Moreover the trephin can rarely be used, the scissors perforator is apt to slip, the thin cranial wall is out of reach, and only the thicker, denser portions of the skull are accessible." Many diverse opinions exist as to the relative facility of perforating and extracting the advancing or the after-coming head. Stahl maintains that the advantages lie with the perforation and extraction of the advancing head. He believes that decapitation and extraction will prove as successful with the normal as with the hydrocephalic head, that a clean cut and less cruel decapitation will find greater favor with the parents than the long drawn out and gruesome operation of basiotripsy, that the method possesses ease of technic and simplicity of execution, and is of ready applicability to those obstetric emergencies which as a rule arise suddenly and must be combated single-handed.

THE POINTS IN COMMON BETWEEN SENILE ENDOMETRITIS AND CANCER OF THE BODY OF THE UTERUS ARE NOTED BY J. LORAIN (*Revue Médicale*), as follows:

1. Blood-stained discharge coming on after the menopause.
2. Offensiveness of the discharge.
3. Periodic pain.
4. Cachectic condition.

Although the group of symptoms is founded in the diseases the points of difference are fairly well marked. Metrorrhagia is always present and occasionally profuse in cancer; whereas in endometritis it may be absent and is rarely large in amount. Offensiveness of discharge is found at an earlier period in endometritis than in cancer, in the latter it only occurs when the nodules of growth break down. In endometritis the odor is due to chemical changes in the discharge retained within the uterine cavity. The discharge is less purulent and more serious in cancer than in endometritis. Pain may be quite absent, and is rarely intense in endometritis; in cancer on the other hand, it is almost always present, except in the early stages. It is always found as soon as the new growth is sufficiently advanced to distend the cavity of the uterus and bring into play the contractility of the organ. We then observe those paroxysmal attacks of pain which Simpson considered pathognomonic of cancer. Cachexia is the same in the two cases, but in endometritis it soon ameliorates as result of treatment. Cachexia may be improved in some few cases by treatment, but the improvement is very slow and not permanent.—*Annals of Gynecology and Pediatry.*

CHARACTERISTICS OF SYPHILITIC ENDOMETRITIS.—At a recent meeting of the New York Academy of Medicine Dr. A. Ernest Gallant stated that he had been impressed with the fact that a peculiar softened condition of the uterus associated with severe hemorrhage, was not uncommonly dependent upon syphilis, and therefore he would always give such patients a course of antisyphilitic treatment. It was difficult to describe the feeling of such a uterus; it was fairly comparable to the sensation imparted on compressing a moist sponge.

Dr. Brooks H. Wells said that the point was an excellent one to remember in practice, as in syphilitic endometritis the endometrium was unusually quite succulent, and curetting gave only very temporary relief. If such an endometrium was reproduced very quickly one should suspect syphilis. In cases in which it was justifiable to remove the uterus because of severe hemorrhage, the curette would bring away very little material, and had no marked effect on the hemorrhages.—*N. Y. Medical Record.*

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

ALBUMINURIA IN DIABETES MELLITUS.—Lecturing on albuminuria in diabetes mellitus, Professor Mariogliano recalls some interesting points. Albuminuria may be functional or due to stasis; again, it may be due to renal lesions either specific to diabetes mellitus or the ones common to ordinary nephritis. From the prognostic standpoint, some have taken albuminuria for a favorable sign from the fact that in some cases at the time albumin becomes evident in the urine, the sugar decreases and even at times disappears, thinking that the beginning of a light albuminuria indicated the happy termination of glycosuria. The truth is that in such cases glycosuria has been bettered by a strict diet and treatment and that albumin in urine has become apparent. That is all. Not always does albuminuria announce a favorable turn. On the contrary in some cases it is ominous. Take for instance cases where it is due to hyposystole (myocarditis) and to renal lesions. Thus, albuminuria has a variable bearing, and of course, when nephritis is otherwise ascertained the prognosis is grave. Albuminuria suggests the consideration of uremia in cases of coma in diabetes. In diabetic coma there is no other sign but that of a profound depression, the pupil even is dilated; in uremic coma there are signs of excitation, the pupil is contracted. In diabetic coma there is no thermic elevation, while there is in uremic coma. Relative to the genesis of coma in diabetes Klemperer has shown that it is the result of auto-intoxication which is the latest view.—[*Gazetta degli Ospedali e delle cliniche*, March 5, 1899.]

ULCERATED HEEL AND OCCIPUT IN THE NEW-BORN AND NURSLINGS.—According to Dr. Raffin [*Thése de Bordeaux, Les ulcérations talonnières et occipitales chez les nouveau-nés et les nourrissons*], the occurrence of ulcerations at the heel and occiput is seen not only in ill-fed and debilitated infants, but in those who have all the appearance of health, and in quite a large proportion, as he observed them in 100 babies at the Children's Hospital, 52 times at the heels and 14 times at the nucha. As a rule, these ulcerations are started and well under way when attention is directed to them; in other words, they begin insidiously and progress by degree.

It is a simple matter to stop their advance when the physician's attention is attracted to the sore spots at an early stage, for mere cleanliness and any desiccant powder will do. But, when the sore is advanced and extended over the size of a dime, erosive in surface and depth, accompanied with secondary infection from surrounding micro-organisms, indicated by inflamed glands in the groin and neck, Dr. Raffin recommends the use of iron sub-carbonate in very fine powder.—*La Revue Médicale*, July 12, 1899.

In a Review of the Berlin Congress on Tuberculosis, the *Gazette Hebdomadaire*, of June 25, gives a good account of the proceedings and of the several discussions.

Opinions differed as to the application of tuberculin or even serum treatment in tuberculosis, some observers qualifying the use of these with decided restrictions. Brieger, of Berlin, was quite clear in stating that the specific action of the many tubercular serums has not been demonstrated thus far.

In the discussion of climate in relation to tuberculosis Sir Herman Weber, of London, considered the climatic factor one of great importance in the treatment of tuberculosis. Cases may recover anywhere, but the selection of proper surroundings is most beneficial. Mountains will suit cases with a robust constitution, so will a journey on sea. The seaboard will suit cases with extensive lesions with hardly any temperature. Inland places will suit cases with a weak constitution. Low, but dry places will suit cases suffering from albuminuria and diabetes. In no instance, where there is fever, should a case be moved to any place. First get rid of the fever, or lower it almost to normal before permitting a change of location, and in all instances the patients must dwell in well-ventilated rooms with a good exposure of the sun.

Dr. Baradat, of Cannes, said that the winter stations on the Mediterranean offered to patients three important auxiliaries: sun, sea and pure air. It is a fact that the bacilli are destroyed by a twenty minute exposure to the sun, and at Cannes, out of the 180 days during which the climatic season lasts, there are on an average 156 sunny days. A constant sea breeze sweeps the atmosphere and purifies it. During the summer months the dwellings are not occupied, and they are thrown open to the sun and pure air, and whatever virus may have remained in the rooms is surely annihilated by the time the winter season returns.

Department of Therapeutics.

In charge of DR. J. A. STORCK, New Orleans, La.

TAKA-DIASTASE AS A MEANS OF DIGESTING STARCH in the stomach has been submitted to the test of direct experiment by Prof. A. E. Austin, of the Chemical Laboratory of Tuft's Medical School.

The experiments were carried on to investigate the following points:

(*a*) The digestion of starch by taka-diastase in a neutral medium, the relative amount of starch and diastase, and also the time required for complete digestion.

(*b*) The action of free hydrochloric acid on the digestion of starch by taka-diastase.

(*c*) Action of free organic acids on starch-digestion by taka-diastase.

(*d*) The effects of free hydrochloric acid on starch-digestion in the presence of albuminized hydrochloric acid.

(*e*) Influence of hydrochloric acid on starch-digestion in the presence of albuminoid foods—both animal and vegetable albuminoids.

(*f*) The action of hydrochloric acid of dog's gastric juice on starch-digestion in a dog's stomach in the normal digestion, with a dose of taka-diastase.

(*g*) Influence of hydrochloric acid of human gastric juice on starch-digestion in the human stomach, both with and without taka-diastase.

After fully describing the particulars of a number of experiments having these objects in view, the professor closes his report by saying that from the results which he obtained the following facts seem to be well established:

1. Taka-diastase digests starch with remarkable rapidity in a neutral or slightly acid medium; and its rapidity is directly proportional to the quantity of taka-diastase used. Taka-diastase in the above medium is capable of digesting three hundred times its own weight of starch in one hour.

2. The digestion of starch by taka-diastase is accelerated and enhanced by the presence of a small quantity of free hydrochloric

acid, while beyond a certain amount the free hydrochloric acid retards and eventually arrests the diastatic digestion.

3. The digestion of starch by taka-diastase is not interfered with by organic acids for all practical purposes; on the contrary, the presence of a small quantity of organic acid enhances the diastatic digestion of starch.

4. The presence of albumin combined with hydrochloric acid seems to lessen the hindering action of free hydrochloric acid on starch-digestion.

5. Albuminous foods—both of animal and vegetable origin—combine with or neutralize free hydrochloric acid of gastric juice, making the acid perfectly inert. The combined hydrochloric acid has no hindering action on diastatic digestion by starch.

6. In dogs' stomachs, when albuminous foods are given with starchy food, no free hydrochloric acid is found at the end of one hour, and in the meantime, starchy foods are perfectly digested.

7. In the human stomach, when an ordinary regular meal is taken, the albuminous matter of the food combines with the hydrochloric acid of the gastric juice as fast as it is formed, at least for a period of one hour, and such combined hydrochloric acid has no hindering action on starch-digestion, and the diastatic digestion of starchy food is practically completed within that period.

As the natural supply of starch-digesting ferment for stomach-digestion is found in the saliva, and as many persons in this age of rush fail to masticate their food thoroughly and impregnate it with saliva, the result is that many suffer from forms of dyspepsia so induced. Malt diastase, found in the various extracts of malt, has become popular because of its ability to aid digestion in this direction. It provides in concentrated form all the active digesting power these extracts possess, so that physicians may know exactly how much they are using, and how much work it can do.—*Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King,
New Orleans.

Asthma as a Reflex Manifestation of Abscess of the Maxillary Antrum.—Dr. Charles W. Richardson, of Washington, D. C., in the August number of the *Laryngoscope*, relates the histories of two cases of asthma which were cured by the treatment of an associated empyema of the antrum of Highmore.

In the first case, a young woman, there existed a chronic purulent fetid discharge from one nostril of several years duration, with which had become associated attacks of asthma, at first periodical and later becoming very frequent and severe. Evacuation of the pus from the antrum gave immediate relief to the embarrassed respiration and the attacks did not recur for eight weeks. Closure of the cavity and a re-accumulation of the pus caused a recurrence of the asthmatic paroxysms which were a second time relieved by drainage of the antrum. This time the cure was permanent.

The second patient was a man of 34 years of age who had suffered for two years with a serious form of asthma that had proven rebellious to all the usual means of treatment. The evidence of an antral empyema of one side was found, which when evacuated was followed by immediate relief to the asthmatic breathing, just as occurred in the other case.

This patient is still under observation and it invariably happens that when the antrum suppuration is neglected for a while and pus is allowed to accumulate in the cavity there is a recurrence of the asthmatic paroxysms.

The author is at a loss to state whether the reflex disturbance was a direct result of the presence of pus in the antrum or was due to irritation in the nose from the discharge of pus through that channel. While nasal reflex asthma has been commonly reported, reflex asthma due to antral empyema has apparently never been described.

The Thyroid Treatment of Middle Ear Disease.—A very thorough and conscientious test of the treatment, with thyroid extract, of deafness due to middle ear conditions has been made by Macleod Yearsley. With a report of 21 cases treated by himself he combines the statistics of 16 severe cases treated by Bruhl, 8 reported by Eitelberg, and 14 by Morpurgo, making a total of 49 cases. Bruhl's cases appear to have been of the chronic sclerotic class of from three to thirteen years' duration, observed in patients between the ages of 20 and 40, in which other methods of treatment had been employed. He made use of the extract in tabloid form, each tabloid representing five grains of the healthy gland, of which he administered one daily during the first week, two daily during the second week, and three daily during the third and fourth weeks. The treatment was then discontinued for one or two weeks and again taken up, a test of the hearing being made once a week by speech acoumeter and tuning forks. Ten of the cases were reported as "subjectively and objectively improved," in four the treatment was "satisfactory," and in the remaining two the result was "very good." In none of them were any unpleasant symptoms manifested. Eitelberg's report is rather indefinite as to the results obtained, but he advises further trial of the agent. Morpurgo claims to have observed a marked gain in hearing in two cases and in two others a diminution of the tinnitus. Nine cases showed no improvement, in four of which there was a considerable loss of flesh, and in two headaches occurred.

The result of the treatment in Yearsley's twenty-one cases was altogether disappointing, whether employed in middle ear sclerosis, the ordinary non-suppurative middle ear catarrh with ossicular anchylosis, or in those cases of loss of ossicular mobility due to former intra-tympanic suppuration. With one exception, all these cases had been subjected to a thorough course of treatment by the usual methods in vogue before being put upon the thyroid treatment. Bruhl's system of treatment was carried out, and in addition to the usual tests of hearing made every week, the mobility of the ossicular chain was carefully watched and tested by means of Siegel's pneumatic speculum. After observing an unbroken series of failures by this method of treatment the author concludes that it is entirely inefficient and unworthy of further trial. Richard Lake has had a similar experience and has abandoned the use of the agent.

The theory of the action of the thyroid extract in these cases was that it promoted the absorption of pathologic connective

tissue, and that it would consequently prove beneficial in cases of deafness due to sclerosis or adhesions in the tympanic cavity affecting the mobility of the chain of ossicles, and that this action was due to the iodin contained in the extract. This theory, as is seen, has not been borne out by clinical experience.
-*The Journal of Laryngology, Rhinology and Otology.*

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Text-Book of Pathology. By ALFRED STENGEL, M. D. With 372 illustrations. Published by W. B. Saunders, Philadelphia.

This book, which treats of the subject of pathology from a clinical standpoint always, is full of useful information for the student or practitioner. The chapters on general pathology, the first eight of the book, are to be chiefly recommended. In the special pathology part the chapters on diseases of the blood, diseases of the respiratory system and diseases of the spinal cord are to be specially commended. We have had this work for some time, and whenever we have had occasion to consult it we have never been disappointed. P. E. A.

A Manual of General Pathology for Students and Practitioners. By WALTER SYDNEY LAZARUS-BARLOW, B. A., B. C., M. D., M. R. C. P. P. Blakiston's Son & Co., Philadelphia.

The work of Dr. Lazarus-Barlow is quite original in its presentation of the subject of general pathology. It is written, with chapters a little long at times, with the intention of developing students' reasoning faculties in the interpretation of pathologic facts. In it pathologic anatomy plays a secondary part, as it necessarily should, and in some cases its details are altogether neglected. Chapter XIII, the pathology of various morbid conditions which are characterized by abnormalties of secretions and excretions, we especially commend. P. E. A.

The Anatomy of the Central Nervous System of Man and of Vertebrates. By PROF LUDWIG EDINGER, M. D., Frankfort-on-the-Main. Translated from the fifth German edition by WINFIELD S. HALL, Ph. D., M. D., Chicago, assisted by PHILO LEON HOLLAND, M. D., and EDWARD P. CARLTON, B. S.,, of Chicago. The F. A. Davis Company, Publishers, Philadelphia, New York, Chicago.

This new edition of Professor Edinger's work, greatly enlarged over the fourth edition, requires no recommendation from us. The translation by Professor Hall from the fifth German edition is indeed a decided improvement over the previous English edition. The lectures of the original have been presented as chapters, requiring an original departure from the original, but partly enhancing the value of the work. No student of nervous pathology can afford to be without this work in his collection.

P. E. A.

Nervous and Mental Diseases. By ARCHIBALD CHURCH, M. D., Chicago, and FREDERICK PETERSON, M. D., New York. Published by W. B. Saunders, Philadelphia.

An excellent work and up to date, and cheerfully recommended to the student and busy medical practitioner. The illustrations are especially good.

P. E. A.

Lectures on Appendicitis and Notes on Other Subjects. BY ROBERT T. MORRIS, M. D. Third edition, revised and enlarged, with illustrations. New York, G. P. Putnam's Sons, 1899.

The work of Morris is too well known to make it necessary to review it at any length. One hundred and three pages of the book are devoted to appendicitis and embody the views enunciated by him in his lectures before the Post Graduate Medical School in New York. Then follow short articles on a great variety of subjects, all of which are interesting and show the great technic skill of the operator. The descriptions are in the usual trenchant style of the author, making them not only instructive, but exceedingly entertaining reading. No matter how one may disagree with him in some of his bold, radical practices, yet one can but admire the technic skill, which can save 98 per cent. of 100 cases of appendicitis of all classes and grades. No surgeon who strives to know both sides of this subject, should be without this book of Morris's at hand.

PARHAM.

Surgical Nursing. By BERTHA M. VOSWINKEL. Second edition. Philadelphia. P. Blakiston's Sons & Co., 1899.

"The aim of the author," according to the preface, "is to give a concise outline of surgical nursing in general, together with a list of antiseptic agents, the mode of preparation of the various materials used in antiseptic and aseptic surgery, and the application of splints and fixed dressings." Many suggestions valuable to the surgical nurse are given, but the work is hardly broad enough to be "an outline of surgical nursing." The various proceedings and preparations are not described with sufficient exactness of detail to render the book valuable as a nurse's vademecum, and distinctions between essentials and elegancies of surgical technic are not made sufficiently clear. Of the more important details insufficiently treated might be mentioned the lifting of patients and the preparation of the nurse's hands prior to an operation.

Some of the numerous statements as to what are the last methods, instruments and materials as well as some of the dissertations upon symptomatology and treatment are so characterized by an arbitrary narrowness (suggestive of a limited experience) as to be misleading. Direct errors are made occasionally, as for instance, "It undergoes no change," in speaking of the blood of intestinal hemorrhage.

Many of the author's hints about nursing proper are so good that it is to be regretted that more space is not devoted to them. On the whole, the book will be of assistance to nurses already grounded in the principles of surgical work, but would be unsafe to put into the hands of beginners.

PERKINS.

Text-Book of Ophthalmology. By DR. ERNEST FUCHS, Professor of Ophthalmology in the University of Vienna. Authorized translation. By H. DUANE, M. D., Assistant Surgeon Ophthalmic and Aural Institute, New York, with two hundred and seventy-seven illustrations. Second American Edition. New York, D. Appleton & Co., 1899. Appleton's Medical Library.

It has given us the highest pleasure to receive a copy of the new edition of Fuchs' Text-Book. We dare not attempt to gild its gold; we could not review it and do justice to its merits without writing another book. There are many excellent texts in our department of medicine, but none that combine so nearly all that a model text-book should. To our mind, it is "the best," and as such we commend it to our students. We can not better the description of Dr. Duane in his preface to the second English edition: "The last or seventh edition * * * in addition to the merits of lucidity, judicious treatment of the subject and excellence of proportion and balance, that have always characterized Professor Fuchs' treatise, bears everywhere the marks of the most thorough revision, of additions and corrections, bringing the book up to date in all its parts, so that it presents an excellent summary of ophthalmological science as we know it to-day."

BRUNS.

An Essay on the Nature and the Consequences of Anomalies of Refraction. By F. C. DONDUS, M. D., late Professor of Physiology and Ophthalmology in the University of Utrecht. Revised and Edited by CHAS. A. OLIVER, A. M., M. D. Philadelphia, P. Blakiston's Sons & Co., 1899.

No ophthalmologist who has more than a commercial interest in his art will fail to have a copy of this wonderful essay, lovingly as it were, published *de luxe* as a tribute to its great author's memory.

Here marveling we stand in the presence of genius, and realize the vanity and insignificance of all mere talent.

BRUNS.

Atlas of the External Diseases of the Eye. By PROF. DR. O. HAAB, Zürich. W. B. Saunders, Publisher, Philadelphia, 1899.

To the student and busy practitioner the author has furnished a most useful guide in the diagnosis of external eye diseases. The work is remarkable for the accuracy of its plates, illustrating in a striking manner nearly every variety of disease within its province. ROBIN.

Retinoscopy. By JAMES THORINGTON, M. D. P. Blakiston's Son & Co., Philadelphia, 1899.

We are glad to note that this excellent little book has been so well appreciated as to call for a third edition within so short a time from its first appearance.

It occupies a unique position in conciseness, simplicity of diction and thoroughness, and hence in every way merits a continuance of favor.

ROBIN.

Essentials of Physical Diagnosis of the Thorax. By ARTHUR M. CORWIN, A. M., M. D.; Demonstrator of Physical Diagnosis, Rush Medical College. Second Edition, Revised and Enlarged. W. B. Saunders, Philadelphia, 1899.

In this attractive manual the aim of the author "to present in systematic form the gist of the science of physical diagnosis as applied to the thorax" has been very successfully carried out. The division of the subject, the arrangement of subheadings and the clear cut sentences of the text, all show a practical acquaintance with class teaching. The illustrations are ample and well selected. The book is of a size to be conveniently carried in a large pocket, a consideration of some interest to students.

PATTON.

A Clinical Text-Book of Medical Diagnosis. By OSWALD VIERORDT, Professor of Medicine at the University of Heidelberg. Fourth Edition, from the Fifth German, Revised and Enlarged. W. B. Saunders, Philadelphia, 1898.

With such a book as this latest edition of Professor Vierordt's masterly treatise the reviewer can do little more than welcome, in its present enlarged compass and handsome form, what is recognized as one of the greatest productions of medical literature of modern times. From its first appearance in 1888 this text-book, covering the whole vast subject of medical diagnosis, has received the most unqualified approval of the entire medical profession. It shows on every page that it is the work not only of a master mind, but of a gifted teacher. Those who have read and admired the earlier editions should not fail to procure this last American edition, which is complete, up to date, and thoroughly admirable in all that appertains to the printer's art. PATTON.

Saunders' Medical Hand Atlasses: Atlas of Diseases of the Skin, Including an Epitome of Pathology and Treatment, by PROF. DR. FRANZ MRACEK, authorized translation from the German by HENRY W. STELWAGON, M. D., Ph. D., with sixty-three colored plates and thirty-nine full-page half-tone illustrations. W. B, Saunders, Philadelphia, 1899.

Besides more than a hundred well selected engravings, the work contains some 200 pages of succinct text. The engravings themselves approach nearly to the actual appearance of the living lesions.

The best school room for diagnosis is the clinic, but clinics are not forthcoming everywhere, and we must all the more thank such men as Dr. Mracek, who send us such beautiful impressions of the best cases in the great clinics of Europe. No one could have a better helper in the study of skin diseases than this little work affords.

The work commends itself to the specialist and to the general practitioner alike. BLOUNT.

Progressive Medicine, A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Vols. I and II. Edited by HOBART AMORY HARE, Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Published by Lea Bros. & Co., 1899.

Only those who have attempted a recent review of the vast field of medical literature can fully appreciate the labors of Dr. Hare and his associates in preparing this most excellent quarterly. It is one of the completest and most authoritative reviews of the advances in medicine and surgery that has yet been made. The chief claim for recognition is that of practicability. The matter has been selected with special reference to practical applications by men who have not only reviewed thoroughly their subjects, but added without restraint their own opinions. The first volume comprises a review of the surgery of the head, neck and chest, diseases of children, infectious diseases, including pneumonia, laryngology, rhinology and otology. The chapter on pathology, especially that part devoted to tumors, shows the vast amount of work being done in this direction. The second volume contains a thorough review of all recent matters in abdominal surgery, gynecology, blood diseases, diathesis and ophthalmology. All the chapters are ably presented, and the publishers have not departed from their standard of presenting serviceable books.

MILLER.

PUBLICATIONS RECEIVED.

Mechanics of Surgery, by Charles Truax, Chicago, 1899.

International Clinics, Vol. 2, 9th Series, 1899.—J. B. Lippincott Co., Philadelphia.

A Text-Book of Pharmacology and Therapeutics, by Arthur R. Cushny, M. A., M. D.—Aberd. Lea Bros. & Co., Philadelphia and New York, 1899.

The Surgical and Minute Anatomy of the Central Nervous System, by H. C. Gardinier, A. M., M. D.—P. Blakiston's Son & Co., Philadelphia, 1899.

Centennial Year—Annual Report of the Supervising Surgeon-General of the Marine Hospital Service of the United States.—Washington.

Louisiana State Board of Health—Sanitary Code—1899.

Thoracic Resection for Tumors Growing from the Bony Wall of the Chest. by F. W. Parham, M. D.—New Orleans, 1899.

International Directory of Laryngologists and Otologists, by Richard Lake, F. R. C. S.—The Rebman Publishing Co., London, 1899.

College Announcements—New Orleans College of Dentistry; Albany Medical College; the Columbia University; Gross Medical College; Tulane University of Louisiana; the Medical College of Alabama; the Jefferson Medical College; University of Oregon; Report for the Year 1898–99, Presented by the Board of Managers of the Observatory of Yale University to the President and Fellows.

REPRINTS.

Treatment of Tuberculosis, by J. F. Peavy, M. D.

Anastomosis of Bladder to Rectum, by Jacob Frank, M. D.

Chemicolegal Testimony.—Strychnin, by G. H. Meeker, M. S., Ph. D.

Principles of Modern Scientific Sanitation and of Modern Scientific Quarantine, by Edmond Souchon, M. D.

Prognosis in Chronic Valvular Affections of the Heart, by N. S. Davis, Jr., M. D.

Modern Possibilities in Chronic Catarrhal Deafness, by Sargent F. Snow, M. D.

Three Practical Points in the Management of Fractures at the Elbow-Joint.—General Considerations upon Major Anesthesia.—Threatened Death During Major Anesthesia.—A Brief Digression upon Shock.—Shock, by R. H. M. Dawbarn, M. D.

The Importance of Blood Examinations in Reference to General Anaesthetization and Operative Procedures, by Hamilton Fish, M. D.

The Case of Mrs. Maybrick, by Mr. Clark Bell.

On the Use of the Valerianates of Creosote and Guaiacol in the Treatment of Pulmonary Tuberculosis, by A. B. Briggs, M. D.

La Neurasthenie et Certaines Affections du Nez et de la Gorge.—Paris.—*La Parole.*

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR JULY, 1899.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	4	7	11
" " Intermittent			
" " Remittent	7		7
" " Congestive	3	2	5
" " Typho	2	6	8
" Yellow			
" Typhoid or Enteric	11	5	16
" Puerperal	1		1
Influenza			
Measles	1		1
Diphtheria			
Whooping Cough	2	1	3
Apoplexy	10	3	13
Congestion of Brain	6	1	7
Meningitis	5	3	8
Pneumonia	13	8	21
Bronchitis	2	2	4
Cancer	5	4	9
Consumption	41	30	71
Bright's Disease (Nephritis)	29	18	47
Uremia	2		2
Diarrhea (Enteritis)	26	12	38
Gastro-Enteritis	7	2	9
Dysentery	2	3	5
Hepatitis	2		2
Hepatic Cirrhosis	4		4
Peritonitis		1	1
Debility, General	2	4	6
" Senile	22	8	30
" Infantile	2	3	5
Heart, Diseases of	26	23	49
Tetanus, Idiopathic	1		1
" Traumatic	4	5	9
Trismus Nascentium	3	7	10
Injuries	18	12	30
Suicide	4	1	5
All Other Causes	93	73	166
TOTAL	360	244	604

Still-born Children—White, 15; colored, 18; total, 33.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 20.57; colored, 32.52; total, 24.26.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.00
Mean temperature	83.00
Total precipitation	5.45 inches

Prevailing direction of wind, southwest.

Smith
Johnston
South Wales

Parham
Wile Eng & [illegible]
Reve

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LII. OCTOBER 1899. No. 4.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

ESOPHAGOSCOPY—ITS APPLICATION IN TWO CASES.*

BY GORDON KING, M. D.,

CHIEF OF CLINIC TO THE EAR, NOSE AND THROAT DEPARTMENT, EYE, EAR, NOSE AND THROAT HOSPITAL, AND ASSISTANT TO THE CHAIR OF DISEASES OF EAR, NOSE AND THROAT, NEW ORLEANS POLYCLINIC, NEW ORLEANS, LA.

Before relating the histories of the two cases which form the basis of this report, and which, I think, present a few points of interest in view of the method employed in their diagnosis and treatment, it will not be amiss to say a word in regard to esophagoscopy and the use of these instruments that I bring before you this evening. In a hasty glance at the history of the esophagoscope, I find that the literature on the subject is rather scanty and inaccessible, and that little I was able to obtain concerning the early use of the instrument was so lacking in clearness of description and detail as to be of little interest on this occasion.

The earliest mention of it that I have found was from the pen of an Austrian by the name of Semeleder, who in the year 1862 wrote concerning esophagoscopy, and I regret that I can get no idea of the method he employed or of his instruments for the purpose. Apparently, however, little attention was given the subject at that time, for no further commentaries appeared until about six years later, when Dr. J. Aylwin Bevan, of London, attempted to describe in the *Lancet*, of April, 1868, an instrument which he claimed to have employed in examining the esophagus for the presence and location of foreign bodies, tumors, etc., but his description is so meagre and incomprehensible that it is not exactly clear how he accomplished his purpose, and whether his results were satisfactory or not. The instrument, it seems, consisted simply of a metal cylinder four inches in length and three-fourths of an inch in diameter, which presumably he introduced into the esophagus and obtained a reflected image of the parts by means of a laryngeal mirror. He later recommended the use of a skeleton frame tube as a substitute for the metal cylinder, as this would permit of the entire wall of the gullet being seen the length of the instrument.

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*Read before the Orleans Parish Medical Society, August 13, 1899.

In 1870, following Bevan, Waldenburg wrote in the *Berliner Klin. Wochenschrift* on esophagoscopy as a new method of examination, and described an esophagoscope of his own invention which he used for the purpose and which at that time gained some recognition.

A year after Stoerck took up the subject, but it was not until 1881 that there appeared to be a general interest aroused on the question, when Morell Mackenzie, Mikulicz, Stoerck and others attempted to revive it. In this country it is rather surprising to note that this means of diagnosis and examination of the pathologic conditions of such an important organ as the esophagus has been the recipient of so little attention, for there is no doubting that it affords us most valuable aid in a certain class of cases. By means of this we are enabled to obtain most definite information as to the nature, form and extent of strictures, and the presence and situation of foreign bodies, and it assures the additional advantage of more accuracy and safety in their treatment.

The principle of the method, as practised at the present day, consists simply in the introduction into the esophagus of a long metal tube, through which, by means of a head mirror, the light is thrown upon the parts and permits of their being inspected and treated under light just as is done for the rectum, the vagina and the other accessible tubular organs.

The patient is made to lie supine upon a table with the head thrown back over the edge to straighten the spine and bring the mouth as nearly in line with the esophagus as is possible, then he is made to undertake, with the assistance of the examiner, what corresponds to the sword-swallowing act of the dime museum. This would appear to be a very formidable procedure, but in reality is readily accomplished in most cases and with not too much discomfort to the patient. In a tractable patient this is *most* easily done without anesthesia, but in children and nervous persons, chloroform may be administered if urgently required. A little cocain sprayed into the pharynx will allay the irritability of the throat and facilitate the procedure. The instrument employed by Stoerck is supplied with a lobster-tail extremity which flexes one way, and in some cases is more readily introduced than the straight tube. This instrument is about eighteen inches in length, and reaches almost to the cardia; the other is shorter and better adapted to younger subjects. For all purposes a diameter of three-fourths of an inch is about the proper size, and this can be used for children over ten years of age with safety. Subjects younger than this require a smaller tube, and the results are not as satisfactory, there being always some risk in lacerating the delicate mucous membrane of the pharynx or esophagus in very young children. Another class of patients in which these instruments are not to be applied are those cases in which there exists some curvature of the cervical spine or marked stiffness of the spine preventing sufficient extension of the head to permit of the tube being introduced into the esophagus. I have recently attempted to examine two cases of this kind, and in both of them the result was unsatisfactory; in one, on account of curvature, and in the other on account of unusual shortness of the neck and loss of flexibility of the spine. These cases must be recognized before attempting the examination and care taken not to force the tube and cause some injury to the soft parts.

For the removal of foreign bodies from the esophagus a long tube forceps has been devised which serves its purpose admirably well. When the object has been found and is plainly seen at the end of the esophageal tube the forceps is passed down through the tube and it is seized and withdrawn without fear of further injury to the parts. If, as may be the case, the body is too large to be taken out through the tube, then this instrument is simultaneously withdrawn.

When by such means foreign bodies in the esophagus can be seen and removed under light it is certainly an advantage over the ordinary methods that we employ, whereby we blindly grope in the depths of the esophagus with a horse-hair probang, or such instruments as the old flexible forceps and the coin extractor, hoping that by lucky chance we may do no harm and may possibly remove the body. When this fails we feel that we have about reached the limit of our resources, and with an uncomfortable doubt in our own mind attempt to assure the patient that the body is not there, as we have been unable to bring it out. After that we simply await developments. It may be even worse if we are sure that the body is lodged in the esophagus and we are unable to remove it. Esophagotomy is then our next resource and is a serious operation and should only be undertaken when urgently indicated. Here the esophagoscope may play a very important role and save our patient from undergoing the danger of a cutting operation, which is a possibility not to be too lightly considered.

In the treatment of strictures also a new avenue of resources has been opened up by the employment of the esophageal tube. A very ingenious method is that practised by Epstein, of Vienna, under whom I had the opportunity of taking some special instruction in the use of these instruments. Where the character of the stricture admits, he resorts to a method of rapid dilatation which he claims to be both effective and safe. The principle of his method consists in introducing into the strictured portion of the canal, with a special instrument for the purpose, a piece of ordinary soft rubber tubing stretched longitudinally so as to lessen its diameter. When the instrument is withdrawn and the tube relaxed it naturally expands and dilates the stricture. The tube is usually left in place for an hour or two, and then drawn out by means of the foreign body forceps or a cord attached to it. Ordinary uterine laminaria tents have been also employed for this purpose, but it seems they are less satisfactory.

Electrolysis and internal esophagotomy for strictures are made plausible by this means, but have not, I think, been yet applied in this manner.

With a long enough tube and a strong light it might be practical to examine the interior of the stomach, which seems to me quite possible under proper circumstances. While these are mere suggestions as to the utility of these instruments, their true worth has already been established in the diagnosis and removal of foreign bodies, and therein, I consider, lies their greatest field of usefulness.

OBSERVATIONS.—The following two cases illustrate in a measure the utility of these instruments when applied to cases of this character:

CASE I is that of a white man, 59 years of age, a night watchman by occupation, who was referred to me by Dr. Ernest Pollack, of this city, to be treated for a difficulty in swallowing, which had been experienced for some weeks past. This was associated with some pain and tenderness over the epigastrium, and considerable gastric irritability. On account of the increasing dysphagia he had been compelled to restrict his diet to semi-solid and liquid food, and even then there seemed to be difficulty in its reaching the stomach. The food appeared to be arrested, so the patient explained, just above the xyphoid cartilage and caused some pain before it entered the stomach, and occasionally, when he drank too rapidly, the liquid would be regurgitated. Patient had lost several pounds weight on his limited diet, and appeared cachectic and enfeebled. Percussion over the liver showed the line of dullness perhaps a little increased, but there was no evidence upon palpation of any nodules or epigastric tumor. Examination of the urine revealed nothing abnormal. No history of syphilis could be obtained. An esophageal sound was introduced and passed down readily until near the cardia, when it appeared to meet with some obstruction. An ordinary sized sound, however, could be passed into the stomach, but would come out usually stained with a bloody mucus of a foul odor. Patient experienced pain when the sound reached the strictured portion. These facts led me to the use of the esophageal tube, by means of which I was able to diagnose a malignant stricture involving the lower portion of the gullet near the cardia.

The Stoerck instrument was introduced with little difficulty to near its full length, and with reflected sunlight could be seen an indurated thickened and discolored portion of the canal, which prevented further passage of the tube. Satisfied, then, that the stricture was malignant and extensive, I decided simply to keep the patient under observation and pass a sound every few days to insure as long as possible the patency of the canal. The patient suffered at times so severely with dysphagia that I gave him a mixture containing cocain, to enable him to take his food with less discomfort. He attended the clinic regularly for about three weeks, and was gradually failing in strength with but little change in the local symptoms, when one day he came in after an absence of four or five days and stated that he was worse, and had scarcely been able to swallow even liquids for four days. This time a very small sound was passed with much difficulty, and I concluded that the growth was beginning to completely occlude the esophagus. The Stoerck tube was again employed, and I could see what I took to be a slough from the growth obstructing the lower end of the tube. With the esophageal forceps I brought out what proved to be a bolus of masticated meat, which had been arrested by the stricture and remained there to act as a veritable ball-valve, shutting off communication with the stomach. After this the patient was able to swallow as before, and felt much relief at being able to resume his diet of milk, soft-boiled eggs, etc. When questioned, he remembered to have attempted about three days previously to eat a small piece of meat, and thought he had succeeded in swallowing it.

Not very long after this the patient developed ascites, and I think went to the Charity Hospital to be tapped. I presume that his liver and stomach were both involved, and that he did not survive much longer.

Case II. A white laborer, 37 years of age, who came to the Eye, Ear, Nose and Throat Hospital and stated that he had accidentally swallowed a pin about two hours before and that he thought it had lodged in his throat. Complained of a sticking sensation about on a level with the thyroid gland, intensified by the act of swallowing, and felt, so he said, as if the pin was stuck cross-wise in the throat. Had tried the usual means of trying to make it go down or come out, but the sensation remained. Laryngoscopic and digital examination revealed nothing in the pharynx, so not having the esophagoscope at hand I decided first to try the horse-hair probang with the hope of bringing it out if it was lodged in the wall of the esophagus. This was done without effect and the patient still insisted that he felt it in his throat and was much alarmed about it. I determined then to use the esophagoscope, and as the patient was very easily managed I succeeded easily in introducing it. By pushing the tube slowly down and as slowly withdrawing it I could examine closely, with the aid of a head mirror and clear sunlight, the entire mucous tract of the esophagus.

The only thing to be noted was a small scratch on the mucous membrane up near the pharynx, probably caused by the pin in its passage down or possibly due to the probang. The pin was not in the esophagus and I was justified in assuring the patient that it had gone into the stomach and would probably pass by the bowels in a day or two. On the third day after this he came and brought me the pin.

BILE AND PUTREFACTION IN INTESTINAL ACHOLIA.

BY OTTO LERCH, A. M., M. D., PH., D.

CHIEF OF CLINIC TO THE CHAIR OF MATERIA MEDICA, THERAPEUTICS AND CLINICAL MEDICINE, TULANE UNIVERSITY OF LOUISIANA, ETC.

Since time immemorial a strong antiseptic action has been ascribed to bile. A statement to that effect has entered every text-book on physiology and on medicine and every treatise on the diseases of the liver up to the most recent times. It is due only to the results of investigations carried on during the last few years that chemists, physiologists and physicians have commenced to doubt this statement. The theory of the antiseptic action of bile, however, has not been abandoned by any means. Waller, in his text-book on Human Physiology (London, 1896), page 198, affirms that bile possesses antiseptic properties, though he adds that it is itself subject to a rapid decomposition.

Semmola and Giofferedi in their work on the Diseases of the Liver (1897, page 482) say that bile possesses an antiseptic action by which it prevents or lessens intestinal fermentation, and add that for this reason, in intestinal acholia, abnormal fermentation occurs with the production of gas, causing meteorism, which may lead to the most serious complications on the part of the intestines.

Olof Hammarsten in a text-book of physiologic chemistry (translated from the German by John A. Mandel, 1898, p. 319) states that the anti-putrid action is not due to neutral or faintly alkaline bile, which itself putrefies, but to the free bile acids, especially taurocholic acid. He bases this statement upon the investigations of Maly, Emich and Lindberger, and gives his own opinion upon this subject by adding that there is no question that the free bile acids have a strong preventive action on putrefaction outside of the organism, and that it is therefore difficult to deny such an action in the intestine; yet he adds that the anti-putrid action of the bile in the intestine is contradicted by certain investigators, viz.: Voit and Roehmann. The success of the Woodbridge treatment in typhoid fever has been said to be due to the constant flushing of the intestines with "nature's own antiseptic," bile. If we consider that it is a daily observation of the clinician that an absence of bile in the intestines gives rise to excessive intestinal putrefaction and the origin of gases that produce meteorism, we can not be surprised that bile should have been considered a strong antiseptic and that this view is still held by some observers.

That the presence of bile in the intestines prevents abnormal putrefactive changes is beyond question, and it is the object of this paper to show how this may be explained satisfactorily without having recourse to antiseptic properties or a specific antiseptic action of bile which in the light of present investigations are, to say the least, not essential.

A short review of the chemic properties and the complex physiologic action of the bile in the intestines will here be necessary:

Bile is a reddish brown or greenish fluid, transparent and of golden yellow color when fresh; its reaction is slightly alkaline, taste bitter, specific gravity 1020-1026; quantity has been variously estimated, but 1500 *c.c.* seems to be generally accepted.

It is a product of the hepatic cells from blood carried by the portal vein to the liver, and is composed of water, mucous matter, glycocholic and taurocholic acids, bilirubin, biliverdin, cholesterin and inorganic salts of potassium, calcium, magnesium and iron. It never contains albumin in the normal condition.

Assisting intestinal digestion is its most important function; it assists in the digestion of fats, of protein substances and of carbohydrates, aiding and acting in concert with the pancreatic juice. When the acid contents of the stomach pass into the intestine they meet with the alkaline bile and are to a large extent neutralized, and the digestive action of pepsin, due to this neutralization, completed by the alkali of the pancreatic juice, is brought to a sudden finish.

The acid chyme coming from the stomach, rich in proteids, gives with bile a precipitate of proteids and bile acids, carrying with it the pepsin which would interfere with pancreatic digestion.

The intestinal digestion thus well prepared can proceed favorably. Since the experiments of Claude Bernard, who proved experimentally that bile alone did not emulsify fats, numerous experiments and observations have shown that the action of bile and pancreatic juice are necessary to make such an emulsion ready for absorption. As to the digestion of proteids, the action of bile is preparatory, that is, it neutralizes the chyme and puts an end to the action of pepsin, permitting the powerful action of trypsin contained in the pancreatic juice upon the proteids, which can take place only in an alkaline medium. The aid the bile affords in the intestinal digestion of carbohydrates is based upon its ability to neutralize the chyme as well as upon a certain beneficial influence it exerts upon the diastatic function of the pancreatic juice (Martin and Williams, as quoted by Hammarsten).

The flow of bile into the intestine corresponds to stimulation of the duodenum, and is greatest about three to five hours, and thirteen to fifteen hours after meals, subject to considerable fluctuations. The pressure under which the bile rests is that of the portal vein, considerably less than that of the arterial system. Bile further has a stimulating effect upon the intestinal muscles, promoting absorption and increasing peristalsis and preventing accumulation of fecal matter in the intestines; and by moistening their mucous membrane it promotes osmosis.

If, after this short review of the complex and important part bile takes in intestinal digestion, we consider the condition of the small intestine in which this process takes place, we find a very large number of various micro-organisms present constantly, reinforced from without and entering with the food.

In large part these are innocuous; but they may acquire pathogenic properties through changed surroundings, and in part they are pathogenic. The staphylococcus pyogenes aureus, streptrococcus pyogenes and bacterium coli, are almost always found under normal conditions*. The medium which fills the small intestines during digestion, on which they exist, is exceedingly favorable for bacterial growth.

Chyle is lymph, plus fat, emulsified; it is a diluted solution of proteids containing fat in a perfect emulsion: so much so that it resembles milk in appearance. It is alkaline in reaction. It is true, however, that the liquid contained in the upper part of the intestines is of an acid reaction due to the activity of micro-organisms changing carbodydrates into lactic, acetic and other organic acids.

That bile does not possess germicidal properties was shown through the investigations of Morgagni, Balochi and Deiler, who reported cases of infection by means of bile. Other observers completed the evidence by proving that bile does not modify the virulence of cultures and by successfully growing cultures in media mixed with bile. It would seem that this is but a repetition of what takes place in the intestines constantly. This evidence, however, was sufficient to modify the views upon the subject. Hammarsten, as quoted, still believing in the antiseptic properties of the bile acids and their activity in the intestines, on page 320 of his work, says: "Although the question of how the putrefactive processes in the intestine under physiologic conditions are kept within certain limits can not be answered positively, still it may be asserted that the acid reaction of the upper parts of the intestine and the absorption of water in the lower parts are important factors. Others, denying the germicidal properties of bile, invest it with a special antiseptic action. Against this, speak forcibly the investigation of Voit and Roehmann, who showed that with a diet consisting solely of carbohydrates and proteids no excessive putrefication takes place in the intestines.

If we grant to bile, then, such a special function of preventing putrefaction in the intestines, according to these experiments, it could be only applicable to fats. It remains now to be stated that bile itself and pancreatic juice are easily decomposed, and that chyle especially enters into a rapid putrefaction on standing.

At first sight at least, it seems indeed strange, with com-

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*Semmola and Giofferedi (*op. cit.*).

plete absence of light, surrounded by moisture and a most favorable temperature for their growth, that this ideal food for micro-organisms of every variety and in the presence of such, should not give constant rise to an excessive putrefaction; certainly it does not, and again we understand how strong antiseptic properties have been ascribed to bile, bearing in mind that its absence immediately produces these changes. If we consider now the action of the intestines when bile is partly or entirely absent, we see that the acid chyme as it passes from the stomach is not neutralized nor the pepsin precipitated; the pancreatin is destroyed: the fat is not emulsified and the epithelial cells of the mucous membranes not moistened by bile are unfit for osmosis; the muscles not receiving their accustomed stimulus act sluggishly, and absorption is seriously interfered with.

Instead of the smooth action of the organism in health, to repeat it, the neutralization and alkalinization of the chyme, the precipitation of the pepsin, the preparation of the mucous membrane, followed by the ready absorption of the continuously manufactured chyle, the rapid removal of the waste matter into the large intestines; all these functions are interfered with and instead we see the large number of micro-organisms constantly present, whose activity during physiologic conditions has contributed aid in digestion, multiply with enormous rapidity in a place that now indeed offers ideal conditions for their growth.

Does this seem strange, and is it necessary to claim for bile antiseptic properties or a special antiseptic action to explain no excessive putrefaction in health? We certainly think not, and should think it rather strange if it were otherwise. It is in perfect harmony with the laws of evolution. It would be a violation to force ourselves to think that an organ, developed through the past ages from a lowly form, constantly adapting itself to ever-changing surroundings, should not be able to take care of itself under ordinary conditions, but should need an antiseptic specially provided to kill germs. If bile possesses a special antiseptic action preventing putrefaction in the intestines, we might allow the same to the pancreatic juice, as disease of the pancreas may produce just such changes as are produced in the absence of bile in the intestines.

Furthermore, are not innumerable micro-organisms of non-pathogenic and of pathogenic nature constantly entering our lungs without being able to damage the organism, until some cause, as exposure to cold, overwork, poverty or the reverse, a life of luxury and excess, have lowered its vitality, and changed its smooth physiologic action so as to convert an unfavorable soil into an ideal place for bacterial growth? How much poverty, frequently coupled with hard labor and usually with bad hygienic conditions, is responsible, is shown by the fact that the most dreaded disease, the curse of mankind, consumption, is justly called the disease of the "proletariat." Epidemics of infectious diseases spread in the quarters of the poor, there finding a ready soil for growth. This shows the cause of the evil, and ought to direct the efforts of the legislator and the sanitarian.

Similar conditions to those existing in the intestines and in the lungs we find in the stomach.

Quantities of micro-organisms of all descriptions enter constantly with the food, and that we find them again in the intestines is proof enough that they are not all destroyed by the antiseptic action of the hydrochloric acid of the gastric secretion. Yet the process of digestion is not disturbed and putrefaction does not commence till the physiologic action of this organ is changed, and then all the hydrochloric acid we can pour into it will not digest a meal, and will not prevent the process of putrefaction.*

An antiseptic function has never been claimed for the pancreatic secretion, nor has it been said that the saliva and bronchial secretion are endowed with an antiseptic function; and it must be granted that the antiseptic action of the hydrochloric

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* As a rule the pathogenic species have rather less resisting power than the common saprophytes, and the micrococci have greater resisting power than many of the bacilli. The difference in the vital resisting power of some of the best known pathogenic species is shown in the following table, which we have made up from determinations made by Boer:

CULTURES IN BOUILON TWENTY-FOUR HOURS OLD, TIME OF EXPOSURE TWO HOURS.

Anthrax bacilius	1—: 1100
Diphtheria	1 : 700
Glanders	1 : 200
Typhoid	1 : 300
Cholera Sperrilium	1 : 1350

—*Sternberg's Handbook of Bacteriology—Antiseptics.*

Tubercle bacilli are not destroyed by the gastric juice, and spores of anthrax bacilli are not always destroyed.—*Falk—Frank—Koch.*

Carvallo and Pachon have shown in a dog with extirpated stomach that putrefying meat could be partaken of without disturbing digestion.

acid in gastric juice is a secondary consideration, and certainly not provided as a special germicide. We need only to remember that even in health, the contents of the stomach are often alkaline and that toward the end of digestion free hydrochloric acid is reduced to a minimum, just at a time when it would be most needed to destroy the more vigorous germs that have withstood destruction during stomach digestion.

The human organism has been aptly compared with an engine. We can enlarge on this and say that during the daily and proper physiologic action there is nothing to note but the general wear and tear. As soon, however, as that process on account of some damage sustained is interrupted, the very oil which served as a protective and to make the various parts glide smoothly over one another now becomes the means of inducing a more rapid decay of the structures.

To say that the intestines do not furnish a proper soil for excessive bacterial growth in health and that the tissues can take care of themselves is natural and explains fully and simply the phenomena observed in intestinal acholia.

To assume an antiseptic function of bile to prevent excessive putrefaction in the intestines is far fetched, not proven and not borne out by the facts.

Does this explanation assist us to treat our patients rationally in intestinal diseases? I think it does. Whether the inflammation of the mucous membrane is located in the duodenum and bile duct or anywhere else in the tract, whether accompanied by absence or presence of bile, it is caused, according to our present views, in all cases by bacterial growths. This being due to a disturbance of the physiologic action of the organ, we will remove the cause, if any is discoverable, such as faulty ingestæ, and insist upon a physiologic treatment; that is, place our patient upon a proper diet and lessen the inflammatory hyperemia with the powerful means furnished us by hydrotherapy to control abdominal circulation. In the large majority of cases this will be found sufficient to restore the organ to its proper function. In the more severe cases, absolute rest and a suitable diet may become necessary, and astringents and antiseptics, cautiously administered, may be found of assistance.

Clinical Reports.

HEMATOMA OF NECK, SIMULATING COMMON CAROTID ANEURISM.*

BY FELIX A. LARUE, M. D., LECTURER AND CLINICAL INSTRUCTOR ON SURGERY, NEW ORLEANS POLYCLINIC; VISITING SURGEON TO CHARITY HOSPITAL, NEW ORLEANS.

W. S., aged 21 years, a robust white railroad switchman, sent for me on January 25, 1899. I found him suffering from contusions of the back and thigh. I also, perchance, noticed a small pulsating tumor in the right cervical region, which, on examination, I thought was an aneurism. I ordered rest in bed for a few days, and suggested that, although he was not in the least bothered with the lump, it would be wiser to extirpate it before it became too large. He, however, heeded not, and kept on working.

On May 26, I was hastily summoned to see my patient, who had been suddenly and for the first time seized with vertigo while stooping over. I found my patient in bed, pale, perspiring profusely, and with an irregular and slow pulse. He had vomited for two or three hours. I advised him to remain perfectly quiet, and saw him again on May 29, when he had another similar attack. I then insisted on the removal of the growth, which I explained to him and to the family was very probably causing the trouble.

The following history was furnished me: On August 23, 1898, he was stabbed five times, once in the chin, once in the right side of the neck, once in the right arm, severing some deltoid fibres, once in the right forearm and once in the right side of chest, with a penknife, the blade of which was an inch and a half long. Witnesses saw him bleeding profusely and very weak. He walked two blocks before he received any assistance, and then with some help he walked within 200 feet of the drug store, when he fell unconscious. He was then carried inside the pharmacy, and was attended by two physicians. When the wounds were dressed he was taken home, and remained in bed eight days. Patient states that he felt the lump in his neck almost immediately after he was cut. Stitches were used, and removed on the seventh day after the first change of dressing. Three days after the cutting his right arm became weaker and weaker, and was almost powerless for over two months. Electricity was applied with apparent benefit, but gymnastic exercises, Indian clubs, and the like, he thought did him more good. He was not able to resume his duties for nearly four months and a half. While at work, during the warmest part of the day, he would suffer with slight headaches and dizziness.

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*Read at Orleans Parish Medical Society, August 13, 1899.

Dr. Parham kindly examined the patient with me, and we both came to the conclusion that we had to deal with an aneurism of the common carotid. I operated at the New Orleans Sanitarium, assisted by Dr. Parham on the 28th of June.

A 1 per cent. solution of eucain B. was used, about 2½ grains being injected altogether. As the pulsating tumor was pointing backward I made an incision parallel to the posterior border of the sterno-mastoid, hoping thereby to more easily pass the ligature around the carotid in close proximity to the tumor. Finding the tumor to be very deep, and still thinking we were dealing with an aneurism, I made an incision along the anterior border of the satellite muscle. I found the carotid and passed around it a temporary ligature, which, on pulling, was found to arrest the pulsation in the tumor. However, even on releasing hold of the ligature we noticed that all pulsation had ceased in the tumor. Did it spring from the vertebral? Was it an aneurismal sac filled with clots?

I incised slowly, through my first posterior incision, down deeply to the tumor, clearing it as best I could. It then appeared as a dark blue mass, semi-solid to the touch, much like a sarcoma. Exploration with hypodermic needle brought nothing, so I gently nicked and incised the capsule of the growth, slowly liberating clots of blood, some laminated. As no bleeding occurred, on thoroughly cleansing the sac, we concluded that we were dealing with a deep seated hematoma following the stab wound of last year. Extirpation not being feasible, I sutured the cyst wall to the skin and packed.

A point of practical interest in this case was that a 1 to 2000 bichloride solution was left on the patient's neck all during the night previous to the operation.

The patient is a blond with delicate skin and the result was a diffuse dermatitis of the neck. I hesitated at first to operate owing to this cutaneous condition, but on Dr. Parham's suggestion, we mopped and gently brushed off the minute vesiculo-pustules, with a ¼ per cent. solution of hydrogen peroxide, then with a 1 to 1000 formalin sol. and sterilized water.

As there was no suppuration whatever at the first and second dressings, the bichloride dermatitis did not complicate matters. The skin of the neck in some places, however, had a honeycombed appearance with slight serous exudation; this latter condition was quickly subdued with applications of compound stearate of zinc with ichthyol.

I discharged my patient entirely cured, on July 15, 1899. He has not had any more vertigo or other troublesome symptoms.

LEPROSY IN ST. MARY PARISH. THREE CASES.

BY ISADORE DYER, M. D., NEW ORLEANS.

Acting under the instruction of Dr. E. Souchon, President Louisiana State Board of Health, I went on July 30 to Franklin and to Patterson, La., to see three cases suspected of leprosy.

CASE No. 1.—B., male, aged 30, residing in the parish of St. Mary, near Franklin. Born in Assumption parish. Has lived for five years in present location. Father and mother both natives of Louisiana, and "Acadians." Has three brothers and three sisters, all healthy. As a boy and youth associated with a man in Assumption parish by the name of Barros, who died about eight years ago with leprosy.

First evidence of his present condition three years ago. Present condition as follows:

Face presents discolored, thickened area between eyebrows running up fan-like over the forehead and down over the nose, which is thickened. Both ears have the lobes thickened, discolored and tubercular. The upper lip has a line of small tubercles along the vermillion border.

The trunk is free and so are the arms and forearms. Both hands are discolored, while each of the little fingers presents typical purplish macules of leprosy. These two digits are bent permanently and equally on either hand.

The feet have faint outlines of leprous macules spreading toward the dorsum of each foot. On the heel of the right foot are two excavated round ulcers with a typical cicatricial periphery. Each ulcer, one beneath the big toe and the other in the middle of the heel, is the size of a silver quarter, and completely anesthetic, as is also an area covering the sole of the foot and a distance one-third up the leg on the inner aspect.

Nasal phonation quite marked. Noticed also interruption during conversation due to shortness of breath. Examination of the oral and pharyngeal areas showed a mass of lesions, tubercles and ulcers. The diagnosis of *mixed leprosy with trophic symptoms* was made by me.

CASE NO. 2.—H., male, aged 24, first seen in New Orleans, and subsequenty at his home in Patterson, La. Well developed and apparently strong and healthy except for the pigment evidence in eruption present.

Father died of pneumonia but had no evidence of skin disease; mother lives with patient in Patterson, in the same house, together with three sisters and the three children of one of these.

One year ago noticed spots on chest; did not consider them of importance; was told that he had leprosy but was not sure of this. Examination of patient developed the following points:

The face, hands, forearms, deeply pigmented a dark dirty brown, attended with much thickening, particularly noticable over the joints of the fingers, in the supra-orbital areas, and in the ears, of which each lobe presents a single large tubercle. The eyebrows have fallen as has the beard from the hairy face.

The trunk, arms, thighs, and legs present typical macules of leprosy, nowheres anesthetic.

A distinct nasal phonation was remarked. The areas of anesthesia were on the forehead and ears. The diagnosis was made of *macular stage of cutaneous leprosy.*

CASE 3.—Mrs. H., mother of case No. 2, gives a history of leprosy of two relatives, both of whom had been seen by Dr. Tarlton, of Patterson, and were known to have died with this disease. Gives a history of having recently developed the present eruption not recollecting it for over three months.

PRESENT CONDITION.—Face almost covered with discrete leprous tubercles, bright red in color and of almost uniform size, that of a hazel nut. Has macules over the trunk and arms, also on thighs and legs. Lesions tested distinctly anesthetic, the anesthesia being deep seated. Nasal phonation marked as in Cases Nos. 1 and 2, although no lesions in either case 2 or 3 were found in the pharynx visible by ordinary examination.

Diagnosis: *Mixed leprosy.*

I wish to express my sincere thanks to Dr. Charles M. Smith and to his son, Dr. Smith, of Franklin, also to Dr. Tarlton, of Patterson, for their courtesy and assistance in aiding me to make the necessary examinations.

Annotation.

WIDAL'S REACTION AND THE RELAPSE IN TYPHOID FEVER.

BY OTTO LERCH, M. D., NEW ORLEANS.

Reading the article contributed by William Sydney Thayer to the volume of "Progressive Medicine," published March, 1899, I find on page 324 the following statement:

> "Although the Widal reaction is now in general use in diagnosis, its significance is quite obscure. Widal considered it as merely a reaction on the part of the body to the infection. Courmont ascribes it to the arousing of the defensive forces of the animal organism, and gives it great weight in prognosis. Chantemesse believed that the appearance of the specific reaction indicated the formation of antitoxin. Grüber saw in the strength of the reaction a correspondingly firm establishment of immunity."

Believing that my views on this subject, published in an article entitled "A Contribution to the Treatment of Typhoid Fever, (New Orleans Medical and Surgical Journal, December, 1897, p. 6)," have been overlooked, I recall them here, as I think, in an appropriate place.

I will preface that I had treated five patients, members of one family, of whom one had a relapse and three a recrudescence, this fever lasting from ten to fourteen days in the various cases. The relapse as well as the renewal of the fever could be traced in each case to emotion; that is, whenever a new member of the family was attacked, another one in whom the temperature had reached the normal, would show a renewal of the fever.

If we consider that the bacilli change the blood through toxins they produce, so that they finally have to die, it seems strange to meet with a relapse after the disease has seemed to have run its course.

However, it is well known that by changing surrounding conditions we can produce changes in the biology of the various micro-organisms. Some of the most virulent bacilli become harmless after they have been cultivated for some time on artificial media or in an unfavorable temperature; parasites are changed into saprophytes and colored bacteria into colorless in a similar way. If we find, on making the Widal test, that the typhoid bacilli, when brought in contact with the patient's blood agglutinate and become motionless, we must come to the conclusion that their cultivation in agar and in bouillion has altered their biology; that there is a difference between the bacilli used for the test and those flourishing in the intestines, in the liver and in the spleen, and that this difference is due to their cultivation, on artificial media in the one case, and in the tissues, surrounded by the toxins they have produced in the other.

The tolerance acquired by the bacilli against the specific toxin will probably vary, and in some, at least, it may be obtained in such a high degree that they will survive when every symptom of the disease has disappeared. They finally will succumb unless a new inflammation, set up by a too early change of diet, by emotion or any other cause, changes and alters secretions, and creates conditions again favorable for their growth.

This seems to explain the phenomena otherwise hard to understand.

Society Proceedings.

MEETING OF ORLEANS PARISH MEDICAL SOCIETY,
August 26, 1899.

DR. LEBEUF reported a case of *spinal sclerosis characterized by extensive unilateral hyperidrosis* in a Frenchman, aged 60, well developed, who had served in the French army in Algiers; no history of syphilis.

There was complete loss of patellar reflex and that of foot. From the head to the foot on the left side there was marked sweating, while on the right side the skin was always perfectly dry, even under stress of excitement or overheating.

Thirteen years ago patient had an attack of grippe, lasting two or three weeks. After this he lost use of left side, the hemiplegia being further evidenced by thickness of speech. Up to the fifth or sixth cervical vertebra, on both sides, there was some loss of sensation, which was less on the right, and absent lower down on the left side. Dr. Archinard had examined the case with Dr. LeBeuf and had concurred in the diagnosis of hemiplegia. Dr. Dyer had also seen the case with him.

Dr. Dyer remarked that this was the most extensive unilateral hyperidrosis he had seen. Cases of localized hyperidrosis were not uncommon. He had seen cases where the sweating was limited to one side of the upper lip, to the nose, to one-half of one extremity, etc. In New Orleans, extensive perspiration frequently produced inflammation of the sweat glands, and cases of hydradenitis limited to one foot or to one hand are frequently seen by him.

Dr. Gessner referred to the *treatment of tetanus with carbolic acid.* Dr. Newell, of King, La., had mentioned this treatment to him in a case where relief was prompt after the first subcutaneous injection of a 2 per. cent. solution. In three or four days the case was entirely cured. He used about 25 minims of the above solution a day. His attention had been directed to this method by an article of Dr. H. C. Wood, Jr. Dr. Gessner referred to the serum treatment in comparison, and suggested that this simple remedy should find a proper field.

Dr. Dabney spoke of the use of calf brains and rabbit brains by hypodermic methods, with which three and two cases respectively had been cured. The treatment was discounted, however, by the fact that abscesses had resulted at the point of injection.

Dr. Tebault quoted three cases he had treated with the antitetanic serum, with no result. One case occurred in a child. There had been no interruption in the course of the disease. He had also used eserin, but could only condemn it. He reported one case of puerperal tetanus from a syringe with which the patient had injected herself for a retained placenta.

Dr. Magruder had recently used serum. If any result had been obtained it was a bad result, as the case was favorable until the serum had been used. He had continued other remedies at the same time (eserin, morphin, chloral and bromide). He gave three injections of serum, but patient died after forty-eight hours. In two hundred cases of confinement the doctor had seen no idiopathic tetanus, but he had seen twenty-five or thirty cases of idiopathic tetanus in infants which had been delivered by midwives.

Dr. Veazie said he had cured five cases which he had treated by keeping them drunk with liquor given in large quantities. He treated children and adults alike. In some cases he used chloral and bromide and salicylate of soda.

Dr. Dupaquier stated that the carbolic acid treatment had been introduced by Bacelli, who claimed 30 per cent. of cures, and he uses as much as a 10 per cent. solution (See April, May and June numbers of the Journal, Department of General Medicine.)

Dr. Walet had treated four cases, all symptomatically. Three of these were traumatic; in one no cause was determined. One case died in twenty-four hours; the other three cases, gunshot, splinter, etc., got well under bromide, chloral, etc.

Dr. Miller asked why cases should occur in New Orleans especially.

Dr. Pettit suggested that the disease prevails in all warm climates. He believed that the serum treatment did not always produce expected results because it was not used frequently enough. It should be given three or four times in twenty-four hours. He referred to the use of the serum in connection with the prophylactic treatment of tetanus. In a case of suspicious injury the wound should be thoroughly washed and cleaned and then dressed with carbolic acid solution, or other disinfectant. The serum injection should be given at once.

Dr. Dabney wished to correct Dr. Miller's impression regarding predominance of tetanus here. He referred to the recent epidemic in New York, attributed to the earth mould and the recent encampment of soldiery near New York. The doctor interestingly referred to the history of the former small birth-rate in the Hebrides and its correction. After some years a French physician had attributed the cause to some condition of infection. Upon investigation it was suspected that tetanus was responsible; cleanliness was established and birth rate began at once to increase.

The doctor referred to facts that he had collected among poor families while he was examiner for a life insurance company. In 1000 families he ascertained that one child in four born was lost, in some instances all four had died. Among this class, midwives are commonly employed and the mortuary records of trismus nascentium is largely drawn from these people. The absence of tetanus in physicians' practice is due to cleanliness and antisepsis.

Here in New Orleans the earth closets afford the best of niduses for the development of the tetanus micro-organism.

Dr. Gessner related an instance of trismus due to the members of the family interfering with the dressing of the cord stump.

Dr. Parham recalled a paper read by Dr. Holliday on this subject, in which attention was called to the pressure on the neck of infants, due to the method employed by nurses in carrying children. Dr. Marion Sims had also referred to this.

Dr. Pettit remembered the paper referred to by Dr. Parham and said that it had impressed him so much that he had directed attention of families to the way infants should be carried. He saw cases of trismus anyhow, however, and they died just the same.

Dr. Dupaquier said that a recent operation had suggested that the delivery of the infant was in itself trauma, and therefore many cases might be purely traumatic from this cause.

The several committees on *Hospital Abuse* reported progress.

N. O. Medical and Surgical Journal.

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

YELLOW FEVER IN THE SOUTH.

Close upon the outbreak of yellow fever at the Soldiers' Home in Virginia have followed the occurrence of a few cases in New Orleans and in Mississippi towns, and quite a number in Key West, Florida.

The Virginia outbreak was promptly controlled by sanitary measures and in a short time, days only, the episode became a thing of the past. While there was some panic and apprehension in neighboring communities, events proved that these were not warranted by the facts.

In Florida, prompt action was taken to isolate Key West by a quarantine which was warranted by the comparatively rapid spread of the disease. New Orleans has again been victimized by the Texas health authority, without the courtesy of conference accorded by Mississippi and Alabama health officers and without investigation of actual conditions.

The conscientious review of conditions this year in New Orleans must appeal to the scientific judgment of medical men, and through them to thinking members of the local and outside communities.

Every sanitary precaution was taken to prevent a recurrence of yellow fever in focuses established in 1897 and 1898. General measures of sanitation were adopted to improve the health conditions of the city. The first case reported in May was promptly isolated and no further cases developed from it. Neither this case nor the subsequent sporadic cases could be traced to infection from focuses of previous years. The disease has not spread and conditions point to the absence of an epidemic this year.

The Boards of Health, State and City, have in every way facilitated the investigation and enlightenment of the Marine Hospital Service and of neighboring health officials.

Quarantines have resulted notwithstanding all this. Texas' quarantine we can fully understand as arbitrary and not the expression of the whole of the State, but as the act of the health officer whose judgment has been governed by his own wisdom. That Alabama and Mississippi should establish active quarantine we can not understand, and for several reasons. In the first place, both of these states suffer commercially by shutting off intercourse with New Orleans. Again the small number of cases and the apparent decreasing severity of type in the disease do not warrant such quarantine.

In the first 250 cases of fever in Key West the mortality was less than 6 per cent., while the morbidity has been quite small up to this writing.

Sanitary measures have practically controlled the disease in Havana; it is now possible to estimate its occurrence in that city, and it is possible to handle it.

In degree, and more forcibly it seems to us, New Orleans has controlled its cases so as to reduce the disease to a no more fearful type than scarlet fever—a disease which is seldom considered quarantinable even though it occurs in epidemic form and with ~~a~~ higher mortality rate than our yellow fever has had in the past three years. New Haven has frequent epidemics of scarlet fever, and within the past three months, even now, in less degree, Houston, Texas, has had cases of scarlet fever in sufficient number to attract outside notice.

We recognize the necessity of a popular understanding of these facts, and we realize that the very people who condemn the health authorities for provoking the apprehension of the disease by announcing it are themselves responsible for the quarantine measures, because in the past they have demanded these.

The experimental work with the pathology and bacteriology of yellow fever has done much to enlighten the public and the profession regarding this disease.

Latterly some controversy has arisen regarding the importance of Professor Sanarelli's discovery, the weight of opinion seeming to be with Sanarelli and the burden of disproof to rest with Dr. Sternberg and his coworkers. The discussion until now has been broad and open; and beyond slight contentions of Drs. Reed and Carroll with Professor Sanarelli's criticism of their work, the review of the status of the whole question is interesting. Among the first to identify Sanarelli's bacillus with yellow fever were Drs. P. E. and J. J. Archinard, of New Orleans, and most reviews now current give them this credit. We feel it the more necessary to mention this fact, as Drs. Wasdin and Geddings, in their recent Marine Hospital Service Commission report, have failed to sufficiently notice the Archinards' work, although the one, Dr. Wasdin, and perhaps the other, acquired much of his familiarity with the bacillus icteroides while privileged to observe the Archinards' experimental work with it. While Drs. Reed and Carroll, in the army laboratory at Washington, and Dr. Sternberg, are withholding final judgment as to the exact role of Sanarelli's bacillus in yellow fever, they have not yielded their claim of the relationship of this bacillus to that of hog cholera.

The Archinards identified the bacillus of Sanarelli in thirty-two of thirty-nine cases, and on autopsy.

The work of the commission of the Marine Hospital Service, consisting of Surgeon Eugene Wasdin and Past Assistant Surgeon H. D. Geddings, must carry a great deal of weight, while its effect upon future developments will be awaited with interest.

The report of this commission is based upon the observation of twenty-two cases seen in Havana and diagnosed as yellow fever by native physicians, and in fourteen of which the commissioners concurred in the diagnosis. The report of the Marine Hospital Service of August 18 concisely presents the conclusions arrived at as follows:

"First. That the micro-organism discovered by Prof. Giuseppe Sanarelli of the University of Bologna, Italy, and by him named "*bacillus icteroides*," is the cause of yellow fever.

"Second. That yellow fever is naturally infectious to certain animals, the degree varying with the species; that in some rodents local infection is very quickly followed by blood infection; and that, while in dogs and rabbits there is no evidence of this subsequent invasion of the blood, monkeys react to the infection the same as man.

"Third. That infection takes place by way of the respiratory tract, the primary colonization in this tract giving rise to the earlier manifestations of the disease.

"Fourth. That in many cases of the disease, probably a majority, the primary infection or colonization in the lungs is followed by a 'secondary infection' or a secondary colonization of this organism in the blood of the patient. This secondary infection may be complicated by the coinstantaneous passage of other organisms into the blood, or this complication may arise during the last hours of life.

"Fifth. That there is no evidence to support the theory advanced by Professor Sanarelli that this disease is primarily a septicemia, inasmuch as cases do occur in which the bacillus icteroides can not be found in the blood or organs in which it might be deposited therefrom.

"Sixth. That there exists no causal relationship between the bacillus 'X' of Sternberg and this highly infectious disease, and that the bacillus 'X' is frequently found in the intestinal content of normal animals and of man, as well as in the urine and the bronchial secretion.

"Seventh. That, so far as your commission is aware, the bacillus icteroides has never been found in any body other than one infected with yellow fever, and that whatever may be the cultural similarities between this and other micro-organisms, it it is characterized by a specificity which is distinctive.

"Eighth. That the bacillus icteroides is very susceptible to the influences injurious to bacterial life; and that its ready control by the processes of disinfection, chemical and mechanical, is assured.

"Ninth. That the bacillus icteroides produces *in vitro*, as well as *in vita*, a toxin of the most marked potency; and that, from our present knowledge, there exists a reasonable possibility of the ultimate production of an antiserum more potent than that of Professor Sanarelli."

The most striking points to our mind are suggested by the observations that *infection takes place by the respiratory tract*, and that the *blood is subsequently infected by a secondary colonization.* Of further interest and importance is the statement that the *bacillus icteroides is very susceptible to the influences injurious to bacterial life;* and that its ready *control by the processes of disinfection*, chemical and mechanical, *is assured.*

CALIFORNIA AND CONSUMPTIVES.

Recently Dr. Crowley, of the California State Board of Health, proposed to that body that the immigration of consumptives to that State should be restricted, and that a quarantine should be rigidly enforced by special inspectors upon all trains, who should see that such persons should be sent back.

This movement has been agitated by the California health authorities for some time, and it has not until now been made tangible. Such radical measures, however, are necessary to create the necessary sense of concern for the public welfare in this particular disease.

While a great number of private sanitariums have been established all over the country for the proper isolation of these cases, excepting New York, we know of no State where such provision is made by the local government. London has for some years had special institutions for indigent and other tuberculous subjects, but nowheres as yet have compulsory regulations been established.

The vastness of the undertaking probably will make a national provision for the unfortunates slow in coming, but the growing necessity must in time bring about the desideratum.

THE LOUISIANA LEPER HOME.

The membership of the Board of Control of the Leper Home has been increased to nine instead of seven as formerly constituted.

The present lease of the plantation on which the Home is located will expire soon, and it is projected that the Home shall be brought nearer New Orleans.

This should be done for several reasons, chief among which are the facilities of treatment afforded, the accessibility and the fact that the majority of known cases of leprosy are in Orleans parish.

These elements and the increase in the number of the board are not the only things necessary to make the acts of 1892 and 1894 effective. The small number of thirty-one inmates does not in any way represent the numerical importance of leprosy in Louisiana, and while this number excuses the existence of the Home, the Board of Control must see to it that the new location shall afford inducements to the leper patients not hitherto provided. Leprosy is amenable to treatment, and its amelioration and cure are possible. Until now no such hope has been offered those afflicted, who have been satisfied to await death under some medical care at home rather than chance the absence of treatment for their fearful disease at the Home.

In its domestic care the Home has had all that could be desired at the hands of the Sisters of Charity in charge, but the original purpose of the institution was not that it should be an asylum, but a hospice where care should be directed not only at the creature comforts, but at the cure of the affliction itself.

With assurance of these things to be desired, we feel that the medical profession must be stimulated to an interest in the Home, which it has latterly ignored.

Medical News Items.

The Mississippi Valley Medical Association will meet in Chicago, October 3, 4, 5 and 6. As this will be at the same time as the Autumn Fête, the occasion promises to be well attended, particularly as a one-fare excursion rate is afforded. An excellent program has been announced.

The Eleventh Annual Meeting of the Tri-State Medical Society of Alabama, Georgia and Tennessee will be held in Chattanooga, October 24, 25 and 26, 1899.

The prospects are good for a fine meeting. Titles of papers to be read should be sent to the secretary, Dr. Frank Trester Smith, Chattanooga, Tenn.

The Woman's Hospital of New York has received a gift of $50,000 from Russell Sage as a donation to the new building, which is to cost $400,000, and is to be erected on the site of the old edifice.

The Barbers of Vienna require that members of their union shall qualify by several years' apprenticeship, and that they shall know the methods of aseptic cleanliness of utensils employed in their occupation.

The *Medical News* states, in this line, that the Province of Quebec has a law, in effect since September last, requiring barbers to stand an examination before the Graduate Barbers' Union. This entails three years apprenticeship, a certificate that he is not suffering from a contagious disease, an examination as to his ability as a tonsorial artist, and in addition he has to answer questions to particularly demonstrate his knowledge of sterilizing razors, combs, etc., used.

A LIQUID AIR CREMATORY is projected in New York. A company has been formed and a site at Nyack, N. Y., selected. Experiments with carcases of animals have demonstrated the practicability of this enterprise.

THE NEW MEMBERS OF THE BOARD OF CONTROL OF THE LEPER HOME are as follows: Dr. C. J. Miller, Mr. Jules A. Gauche, Mr. Lawrence Fabacher and Mr. Theodore Lyons. General Allen Jumel and Judge Frank McGloin some time members of the board, recently resigned.

AMONG THE MEDICAL ABSENTEES during the past summer were Drs. S. E. Chaillé, O. Joachim, J. D. Bloom, A. W. de Roaldes, S. R. Olliphant, J. M. Batchelor, H. S. Cocram, Chas. Chassaignac, C. J. Landfried, J. B. Elliot, Jr., and F. W. Parham.

DR. J. N. ROUSSEL has returned to New Orleans, giving up his location in Mer Rouge, La.

MAJOR SURGEON FLOYD M. STEWART, formerly with Hood's regiment, spent several days in New Orleans recently. The doctor has decided to locate in St. Louis.

NEW SOUTH WALES HAS A SPECIFIC LAW FOR INEBRIATES directed at the control of such upon proper evidence of their condition. Such persons may be confined for not more than 12 months, which term may be increased indefinitely by repeated commitments for cause. The law broadly handles the inebriate as belonging to the insane group, and makes provision for property guardianship, etc.

The confinements may be directed or allowed simply under an attendant in a private institution or in a licensed or public institution. Altogether the act is far-reaching and full of wise legislation.

Louisiana has a law similar in the provision for the care of inebriates, but without the specific detail as to period of confinement, definiteness of evidence necessary, and the act (157, 1894) is quite loosely worded as to the character of the institution, leaving a wide field for profit at the hands of charlatans and fake institutions.

A HAWAIIN LEPER was recently returned to Molokai after having gotten into the United States by way of Canada.

A LEPER IN BALTIMORE recently died, aged 32, after having been isolated for 2 years in a Baltimore hospital.—*Jnal. Am. Med. Assn.*

TOXICOMANIACS in France embrace those addicted to morphin, cocain, ether, like poisons, and alcoholics. The Society of Medicine and Practical Surgery of Paris has suggested legislation for this class, to-wit: that they shall be taken care of by public charge and under legal process, but with their own formal consent, and in a place selected by the afflicted one, who shall remain long enough for a cure, the time of which is to be fixed in advance and approved by the victim.

It seems that this has been urged as broadening the usefulness of a previous law (1838), compelling confinement of this class with or without volition.

THE MICHIGAN LEGISLATURE RECENTLY PASSED A LAW forbidding the marriage of any one suffering from gonorrhea or syphilis, and provides that anyone so diseased who may marry shall be guilty of a felony punishable by a fine of not less than $500 nor more than $1000, or imprisonment in the penitentiary for a term of years not exceeding five, or by both fine and imprisonment. A wife or husband may testify against his or her guilty spouse, and the privilege of medical secrecy is also abrogated in such cases.—*Medical Fortnightly*, September, 1899.

THE BUBONIC PLAGUE is reported at Oporto in Portugal.

A Treadmill for Consumptives has been constructed at the Cincinnati Hospital in order to give these patients more exercise and regular exercise in a limited space.

The Canary Bird as a Source of Tuberculosis is the latest. Tuberculosis is quite common in birds, and as 400,000 are sold annually in Great Britain, and as many people have the habit of kissing canaries, it is considered probable that many cases of tuberculosis can be traced to this origin.—*Exch.*

Professional Secrecy Preserved by Law.—Governor Roosevelt has signed an amendment to the Civil Code of New York which absolutely prohibits a physician from divulging any information concerning one of his patients before or after death of the latter. Up to the present time the insurance law has permitted the physician to testify concerning the physical condition of the policy holder.—*N. Y. Med. Times.*

German Army Regulations require all its physicians and surgeons to shave their beards and mustaches; this measure is due to the discovery that many dangerous bacteria may become attached to the beard.

The New Orleans Polyclinic will open November 20.

The International Conference for the Prophylaxis of Syphilis.—This conference, which has been held this week in Brussels under the honorary presidency of M. de Bruyn, Minister of Public Works and Agriculture, has had before it a vast amount of information collected with great labor and at no slight cost. Reports upon prostitution and the prevalence of venereal diseases have been prepared for nearly every civilized country in the world, which form, when printed, a thick volume of over 700 pages. The reporters are: For England, Dr. R. C. Drysdale; for France, Drs. Ozenne and Julien; for Germany, Dr. Blaschko and Professor Neisser; for Austria, Professor Finger; for the United States, Dr. Isadore Dyer: for Italy, Prof. Tommasoli and Dr. Bertarelli. In addition there were presented reports upon the social dangers of syphilis and gonorrhea, upon the relation of prostitution to the propagation of venereal diseases and upon the part played by other conditions in their dissemination. These reports contain a mass of data gathered from official sources which is undoubtedly of great value, although it is needless to add that the reporters have their own opinions, and all have not been able to avoid coloring their conclusions with the tone of their own minds. Naturally in a discussion of this kind few take an active part who are not partisans, but it it is fair to say that many of the reports have been written in a perfectly impartial manner. The business of the conference has been arranged under six headings: 1. Have the systems of regulation actually in vogue had any influence upon the frequency and the dissemination of venereal diseases? 2. Is the present system of medical inspection of prostitution capable of improvement? 3. From a purely medical standpoint is there any advantage in keeping recognized brothels or should they be suppressed? 4. Is the administrative organization of police supervision capable of improvement? 5. By what legal measures can the number of women living by prostitution be diminished? 6. Apart from prostitution what legal measures can be taken to wage war effectively against the spread of syphilis and venereal diseases?—*British Medical Journal*, September 9, 1899.

TULANE UNIVERSITY MEDICAL DEPARTMENT.—It has been thought advisable by those in charge to defer the opening of the Medical Department of Tulane University for a short time, as announced in our advertising department. Although no danger is to be apprehended by any wishing to pursue their hospital work here, still the decision is a wise one, and will in no way prevent the classes being full when the session does open, just as they were two years ago, when there was really much more cause for postponement than now exists.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

The Influence of Nerve Section on the Healing of Fractures.—G. Muscatello and D. Damascelli. (*V. Langenbeck's Archiv., Bd. LVIII, Hft. 4.*) The question, in what way the section of nerves influences the healing of breaks in bone, has been variously answered. The most recent researches of Kapsammer and Biagi come to opposite results. Muscatello and Damascelli thereupon proceeded to check up their experiments on young animals under well defined conditions. Their conclusions established in general the recent views of Kapsammer, that nerve section has no influence on callus formation that can in any way be said to rest upon a direct angioneurotic basis. The bone repair took place in the fractured bone on the side with nerve section as well as it did in the one on the other side where the nerve was left intact. The processes of repair were found to be exactly the same with intact or cut nerve, that is the phases of the process: the variety of consolidation by bony callus, remained always the same. It was further shown that other results than those were dependent upon technical errors, such as ineffective adjustment of retentive apparatus, permitting bone displacement with abnormal motion and consequent over-stimulation of callus building, which is more apt to happen in the case of nerve injury, because of the loss of sensibility. On the other hand, the occurence of bone atrophy is not to be ascribed to nerve injury, but rather to the inaction consequent upon the lost innervation. The interrupted nerve current thus gives only indirect occasion for bone atrophy.

The most important conclusion from the work of the Italian authors is undoubtedly that the consolidation of solutions of continuity of bone may manifest a normal course independently of the influence of the nervous system.—Translation of an abstract in *Centrbl. f. Chir.*

A NEW METHOD OF INTESTINAL ANASTOMOSIS BY INVAGINATION.—Morisani (abstract from *Centr. f. Chir.* in *Philadelphia Medical Journal,* September 16) believes that the usual methods of performing intestinal anastomosis by the use of a button, or some other similar contrivance, is bound to give a considerable percentage of unfavorable results, because a foreign body is introduced into the intestine. It is true that the majority of cases recover perfectly, but the exceptions show that a certain danger exists. To avoid this disadvantage he has devised the following method: After resecting the bowel the distal end is seized and a ring of mucous membrane from 4 to 6 millimetres wide is cut away from its upper end with the scissors; the proximal end is then invaginated into the distal end and is held in place while two or three fixation sutures are placed, and then the anastomosis is completed with a continuous silk suture. This brings the end of the lower segment, denuded of its mucous membrane, into contact with the serosa of the upper segment, and rapid union takes place without any danger of stricture or any other complication. He has performed the operation a number of times experimentally on animals, and has examined the state of the sutures at periods varying from twenty-four hours to three months from the time of operating. The intestine has been found water-tight in all cases, and it retains its normal character.

[This is certainly a good procedure, but no claim to originality can justly be made for it.]

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER,
New Orleans, La.

THE INDICATIONS FOR CESAREAN SECTION as compared with those for symphysiotomy, craniotomy and premature labor are discussed by Fancourt Barnes (*Annals of Gynecology and Pedeatry*). He contends that the practice of obstetricians of repute in the present day is to widen the limits previously enforced for the performance of the Cesarean operation. The mortality of 81.2 per cent. which attended the operation twenty-six years ago is now little higher than that of ovariotory. Thus Leopold of Dresden has reported fifty cases with maternal mortality of 8 per cent. and Olshausen last year reported twenty-nine cases with mortality of only 6.8 per cent. This improvement is due entirely to the improvements introduced during this period in the technic of abdominal surgery, and especially in the method of sutturing the uterine wound.

Symphysiotomy must of necessity be very strictly limited in its application by the amount of pelvic space available. The amount of increase in the conjugate which can be safely obtained in this manner without injury to sacro-iliac synchondrosis is only one-half an inch; the operation is therefore only applicable to a small number of cases, viz: those which lie just outside the limits within which delivery by forceps or turning can be effected. It is not a method of delivery, but a method of facilitating delivery, applicable to only a small class of cases. The mortality has always been and remains high, for such an apparently simple operation.

The mortality prior to 1860 was 36.1 per cent. for mothers and 44.4 per cent. for the children. Later, in the hands of Pinard, the mortality was 10.84 per cent. for mothers and 14.6 per cent. for children. Thus the mortality of symphysiotomy in the best hands is at present nearly double that of Cesarean section.

In the above article attention is called to the record of deliveries in the Royal Maternity Charity of London, which is almost unparalleled. During the past ten years no less than 40,000 women were delivered. In not a single instance was Cesarean section indicated; only 228 cases required the assistance of forceps, and of these 228, only one woman died. We therefore find that forceps are required in only 5 per thousand of all cases of labor; craniotomy was required in only 14 cases. Version was called for in 52 cases; here also only one woman died. The explanation of this remarkable fact is attributed to the absence of pelvic deformity in the metropolis of London. This absence is undoubtedly due to the improved and still improving hygienic conditions under which the poor of London exist.

ABORTION IN ACUTE PERNICIOUS VOMITING OF PREGNANCY.—Most women who die from acute pernicious vomiting are lost either through undue delay induced by the phantom hope in the doctor's mind that each day the nausea may cease, or from exhaustion during the performance of abortion. How long should we wait must be answered by asking ourselves: "Can we safely perform an abortion to-morrow?" Inasmuch as patients of this class are held back from death by rectal nourishment, which, if withheld for even twenty-four hours, could easily cause death, the conditions for performing an abortion are distinct from those of abortions in general. The ideal, which is to secure complete separation and expulsion of the unruptured ovum, can not be followed. Tampons can not be safely employed, nor can slow dilatation of the cervix be depended upon. In an editorial in *Obstetrics* (August, 1899) the following method is deemed the most applicable to such cases: "A hypodermic injection of strychnin and digitalis, a high rectal injection of hot artificial blood-serum and moderate anesthesia with ether. Then rapid dilatation of the cervix to a degree depending on the period of pregnancy. For less than eight weeks' gestation the cervix need not admit more than the end of the little finger. If the case is at the limit at which this disease is apt to appear, fourteen weeks, dilatation need not admit more than the ring finger. Such dilatation can be procured in a few minutes. A small sharp curette should then be introduced and made to not only thoroughly separate the decidua vera and serotina, but to break into small pieces the entire contents, including the embryo. The latter's body is early resolved into such small bits as to readily pass out of a small cervical canal. The curette will then be used to bring the debris to the internal os uteri, when it will pass out. The curette can then repeat this action until all the larger parts of the ovum have been expelled, after which sterilized water can be used to wash out the remainder. By this rapid method hemorrhage will be very slight; in some cases not an ounce of blood will be lost."

THE COMMITTEE APPOINTED TO INVESTIGATE THE EFFICACY OF ANTI-STREPTOCOCCIC SERUM in the treatment of puerperal sepsis, after a thorough study of all the cases reported, has submitted the following conclusions:

1. A study shows 354 cases of puerperal infection with a mortality of 26.6 per cent. When the streptococci were positively demonstrated the mortality was 33 per cent.

2. Marmorek's claim that his anti-streptococci serum will cure puerperal infection is not thus sustained.

3. Experimental work has cast grave doubts upon the efficiency of the work, demonstrating that the serum which is obtained from a given streptococcus may protect that animal from that organism, but is absolutely inefficient against another variety of streptococcus. Thus the number of serums must be limited only by the varieties of streptococci that may exist.

4. Thus far the only definite result of Marmorek's work is the development of a method by which the virulence of streptococci may be increased to an almost inconceivable extent.

5. Personal experience of the committee has shown that the mortality of streptococcus-endometretis, if not interfered with, is something less than 5 per cent., and that such cases tend to recover if nature's work is not undone by too energetic interference locally.

6. Curettage is unhesitatingly condemned, and also total hysterectomy in streptococcus infection after full term. A part of the excessive mortality in the literature is attributed to the former operation.

7. In puerperal infection a portion of the uterine lochia should be removed by a Doederlein's tube for bacteriologic examination, and an intrauterine douche of from four to five litres of sterile salt solution given just afterward. If the infection is due to streptococci, the uterus should not be touched again, and the patient should be given large doses of alcohol and strychnin if necessary.

8. If the infection extend toward the peritoneal cavity, and in cases gravely septicemic, Pryor's method of isolating the uterus by packing the pelvis with gauze may be of service.

9. The experience of one of the members of the committee seems to show that it has no deleterious effect upon the patient, and therefore it may be tried if desired. But we find nothing in the literature, clinical or experimental, or in our own experience, to indicate that its employment must markedly impress the general result in the treatment of the condition.—*Trans. Southern Surg. and Gyn. Ass'n.*

American

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

NON-DIABETIC GLYCOSURIAS.—A distinction should be made between diabetes mellitus and glycosuria. Under the latter denomination should not be involved the many glycosurias occurring temporarily from an increase of the physiologic amount of glucose in the blood, or from a transient disturbance, viz.: malarial attack, epileptic seizure, strangulated hernia, cholera, anesthesia, asphyxia, intoxications (curare, carbon oxide, phlorizine, urane nitrate, nitrobenzine, etc.)—all conditions analogous to the experimentation of the physiologist who in his laboratory can produce and arrest at will *glycosuria.*

Glycosuria of a more persistent character is that which is mistaken for diabetes mellitus. Yet it should be differentiated from it.

Diabetes mellitus is a clinical entity involving other symptoms than glycosuria. It can exist without glycosuria. In fact, at the time glycosuria disappears in many cases of diabetes mellitus, the stage is one of aggravation, if not of fatal termination. All the symptoms in diabetes mellitus indicate severe nutrition changes and final organic disintegration.

The lasting glycosurias spoken of here, not due to the diabetic condition, have a common feature which serves to distinguish them as a class—they are symptomatic—and they may be divided in the following manner upon the study of their etiologic factors:

I. *Intermittent Glycosuria in Arthritics:*
   - (*a*) Hereditary arthritic glycosuria in young subjects;
   - (*b*) Gouty glycosuria in adult and old age;
   - (*c*) Glycosuria in obesity;
   - (*d*) Azoturic glycosuria.

II. *Digestive Glycosurias:*
   - (*a*) From excessive alimentation with sweet and starchy food.
   - (*b*) From disturbances of digestion.

III. *Nervous Glycosurias:*

- (*a*) In systematic affections of the nervous system (brain, bulb, medulla and nerves);
- (*b*) In neuroses and psychoses;
- (*c*) Traumatic glycosuria.

IV. *Puerperal Glycosuria:*

—*Les Glycosuries non Diabétiques par Germain Roque, 1899.*

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Roentgen-Ray Injuries.—Physicians have become familiar with the serious injuries that occasionally result from Roentgen-ray examinations. It is customary to speak of them as "burns," perhaps from the appearance of the persistent sloughy ulcers in which they are apt to culminate. But burns are universally recognized as injuries due to heat or to the contact of corrosives. A burn occurs at the moment that heat is applied, although there may be secondary lesions of slow development. As for the burn itself, it is produced instantly. On the other hand, the injuries that result from exposure to the Roentgen rays are slow in making their appearance. Usually, according to Dr. Daisy M. Orleman, the "period of incubation" is from ten to twelve days, and in Dr. Orleman's own case, reported in the *Medical Record* for July 1, it was twenty-one days. Hence it is futile to argue that these injuries are not due to the action of the Roentgen rays because Roentgen declares that they "have no calorific effects." Whatever may be the agent that gives rise to these frightful injuries, it certainly is not heat, although a burning sensation may be felt at the time of exposure. Probably the lesion is the result of paralysis, more or less complete, of trophic nerves of the area involved.

There are several points in Dr. Orleman's case that are worthy of mention, besides the length of time that intervened between the occurrence of the first symptoms of trouble. Some of them are the following: The severe pains, which often prevented sleep and were not controlled by local analgesics and anesthetics, but often called for the internal use of morphin; the fact that local treatment proved powerless to check the lesion until prolonged rest in bed was enforced; and the fact that finally, when skin-grafting was resorted to, the grafts "took" on tissue that was gangrenous. But the point that seems to us to call most for comment is the fact that Dr. Orleman's ten months of suffering were wholly unnecessary, for the simple reason that the Roentgen-ray examinations (there were three of them) were themselves utterly uncalled for. A fracture of the femur had been recovered from, and the limb was in every way perfect, but one of the surgeons concerned in the case wished to have the rays applied, for what reason is not stated. We believe that, in view of the injuries that sometimes result from their employment, it is wrong to resort to them unless there is a reasonable presumption that their use will reveal some important feature of the case that would otherwise elude recognition; and our belief is that cases in which this is true are comparatively rare. Unfortunately, the point has been raised in at least one malpractice suit that the surgeon was guilty of neglect because he had not made an X-ray examination of the patient. We are firm in the opinion that the profession should with all its might repudiate this proposition, if the prospect is that it will be held to be generally applicable in cases of fracture.

We are quite aware that there are practitioners of large experience in Roentgen-ray observation, men for whose professional attainments and acumen we have the utmost respect, who declare that there is no danger in such examinations if they are conducted with the proper precautions; but, we confess, of this we are not convinced any more than we are satisfied by the declaration of eminent men that chloroform is as safe an anesthetic as ether. Still, we recognize how difficult it is to restrain enthusiasts and those who can not bear to admit that others have done what they have omitted to do. We adjure such persons, however, to observe the precautions in their X-ray examinations that experienced observers have recommended, for example, those formulated by Dr. F. H. Williams, of Boston (cited by Dr. Orleman), as follows: Place the Crooke's tube two or three feet away from the patient when the fluorescent screen is used, and three feet more away from the plate in taking Roentgen-ray pictures; and, as suggested by Tesla, interpose between the patient and the tube a thin screen of aluminum, grounded by being connected with a proper wire to the gas pipe.—*New York Medical Journal.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King,
New Orleans.

The Close Relation Between the Nasal and Cranial Cavities as a Cause of Brain Disease.—Under this heading William C. Krauss, of Buffalo, writes an interesting article in the first edition of the *Medical Quarterly*, in which he ventures to throw some light on the rather vaguely understood relation of the nose to the brain. Being impressed with the intimate anatomic relation of the nasal and cranial cavities through the thin cribriform plate of the ethmoid bone, he is led to believe that their physiologic and pathologic kinship must be more intimate than is generally recognized. With no little logic, he refers to the ethmoidal plates as the "ventilators" of the brain, basing his theory upon the supposition that osmosis may take place through this medium between the currents of air passing through the nasal chambers and the cranial contents. In other words, that the brain receives some of its supply of oxygen directly through this channel. He cites the facts proven by Ziem, that when in young animals one nostril was sewed up the corresponding side of the head was badly developed, and, as is demonstrated by autopsy on human subjects, where nasal obstruction has existed for a long time on one side, thereby preventing adequate ventilation, the cerebral hemisphere on that side is imperfectly developed.

Some evidence of this is observed in children suffering from aprosexia the result of adenoid growths of the post-nasal space or other forms of nasal obstruction. The mental hebetude of a person suffering from an acute coryza is ascribed to that cause. The pathologic importance of this close relationship would seem apparent also when we consider the number and variety of pathogenic bacteria to be found in the nose. The result of investigations go to show that cerebro-spinal meningitis often begins with violent rhinitis and that infection of the meninges probably takes place through the nose. The germ is often found in the nose in these cases. In view of all these facts, Krauss enters a plea for more careful attention to the hygienic cleanliness of the nasal cavity.

ARGYRIA AS A RESULT OF REPEATED APPLICATIONS OF SILVER NITRATE TO THE THROAT.—An interesting case of this kind is reported by Dr. J. Meneau in a man 73 years of age, who, thirty years before, while under the impression that he had syphilitic ulcers of the mouth and pharynx, made repeated and numerous applications of nitrate of silver to the parts. In the course of time this caused the mucous membrane of the mouth and pharyngeal wall and the skin of the forehead and chest to assume a bluish lead color. A mucous polypus was removed from his nose, and this also was stained in patches of the same color. Chemical examination revealed the presence of silver in these stains. Although argyria from this cause is infrequent, similar cases have been reported by Krishaber, Duguet, Hutchinson and others, all due to frequent and long-continued applications of silver nitrate to the pharynx or mouth. It is probable that the absorption of the silver salt takes place chiefly by deglutition, and where local applications are made in the throat the deglutition of the desquamated epithelium and of the excess of solution used accounts for the dissemination of the salt to the other tissues and organs. Permanent staining of the parts to which it is applied may also occur without further dissemination. Usually the exposed parts of the skin, the mucous membranes and the internal organs seem to be most affected.—*Archives Internationales de Laryngologie, d'Otologie, etc.*

Miscellaneous.

A SUGGESTION FOR SCIATICA.—Kuhn in Germany (*Allgem. Med. Centr. Zeit.*) obtained excellent results in sciatica by injecting equal parts of antipyrine and water directly into the sciatic nerve near its origin.

EUCALYPTUS TREES ARE TO BE PLANTED IN CUBA as an anti-malarial agent. These trees have done much good in Italy, in Rome and in Mexico, the death rate falling off materially in these places after their introduction.

FOR WARTS.—Bichromate of potash in concentrated solution is recommended for the removal of warts. The solution is applied once a day.—*Kansas City Med. Rec.*

Chrysarobin in collodion has also been recently suggested for this purpose. The top of the wart is scraped or pared and the application of ʒi of chrysarobin to ʒi of collodion is made.

TANNIGEN, in doses of 2 to 5 grains, is recommended for chronic intestinal catarrh. It is tastless, so is easily administered to children.

MEDICAL EDUCATION IN JAPAN.—The *Sei-I-Kwai*, of February 28, 1899, publishes an interesting article from the pen of S. Suzuki, M. R. C. S., L. R. C. P. (London) giving the history of medical education in Japan from its origin under the Taikoon government to the present day. There are two present medical faculties in Japan, in the Tokio and in the Kioto Universities. There are also five medical departments in the higher schools in the provinces of Chiba, Sendai, Okoyama, Ishikawa and Nagasaki. Besides these there are the two medical institutions in Tokio under private management, called the Tokio Charity Hospital Medical School and the *Saisei Gakusha* Medical School. The army and navy academies also instruct their surgeon probationers and regular medical officers.

The Tokio University Medical School faculty number seventeen, with six assistant professors and a number of other assistants.

The course of study embraces four years. In the first year the students are instructed only in anatomy, histology, physiology and general pathology. The fourth and last year provides a very elaborate curriculum.

The article concludes with an enumeration of how many kinds of medical men now exist in Japan.

1. Graduates of the University, 1470.
2. "Tokugyoshi" of the medical departments of the five higher schools, 1582.
3. Those qualified in the provincial medical schools, 2038.
4. Those who received the license to practice medicine by virtue of their professional history, 1359.
5. Those qualified in foreign medical institutions, 46. Their diplomas entitle them to the license to practice medicine.
6. Those who received the license to practice by virtue of their State examination, 8467.
7. Practitioners, before the present regulations were passed, received their license without examination; their number amounts to 23,956.
8. Practitioners allowed to practice in a limited district, 474.

The total number of medical practitioners now in Japan amounts to 39,392.

Those from 1 to 6 are physicians who were educated under the modern system. Among the 7th class there are about 10,000 who were educated more or less under the modern system. The remainder are purely followers of the Chinese doctrine—bone setters, shampooers, acupuncturers, priests, etc.

Those of the 8th class received a temporary license in districts where no regular physician resides. Most of them are sellers of nostrums, charmers and midwives. Therefore in Japan over one-third of the practitioners are really ignorant of modern medicine.

THE CUTANEOUS PARATUBERCULOSES.—Under this title, Dr. J. C. JOHNSTON gives an outline of this group of conditions:

There is a class of skin-affections analogous to the parasyphilitic, which may be called paratuberculoses. They are not in themselves tuberculous, but develop and flourish on a tuberculous soil.

They may be divided into three groups; scrofuloderms, tuberculides and dyschromia:

(*a*) The scrofuloderms are pure pyodermias, by which characteristic they are separated from the next group, which are only accidentally pustular.

(*b*) The tuberculides include a variety of affections, ranging from erysipelas persistans to lichen scrofulosorum, which are toxidermias, their characteristic in common. Those which approach lichen scrofulosorum more closely exhibit evidence which precludes the consideration of any toxin other than tuberculin. The status of others (*e. g.* lupus erythematosus) is in great doubt.

(*c*) Tuberculous dyschromia includes only one affection at present, hyperpigmentation, which, except for its peculiar distribution, is that seen in many other cachexias.

The points which determine diseases of this group are: Absence of tubercle bacilli, proved by microscopic examination and inoculation; occurrence in scrofulous or frankly tuberculous patients in more than a bare majority of cases; a pathologic anatomy at least comparable to that recognized for tuberculosis; and finally, if possible, as in the case of lichen scrofulosorum, experimental production of the disease by injections of tuberculin.

The paratuberculoses include many of the affections whose relationship to tuberculosis have been debated at great length in recent years, and as this point alone is under consideration, only questions of symptomatology, etiology and pathology are considered. The argument on this account is valuable as tending to more exact classification in dermatology.

The article gives in detail the various affections classed in each division, showing wherein they should be so arranged in pathologic relation.—*Phildelphia Monthly Medical Journal.*

Retention of a Fetus of Four and a Half Months.—Thirty-four weeks after the last menses, said fetus, apparently of four and a half months gestation, was born.

During the last two months, the mother had been under the treatment of Dr. Adolphi, who saw that during that time the uterus gradually diminished in size. The birth of the fetus took place spontaneously, and was easy. The fetus was somewhat mummified. The placenta had to be removed manually, and looked as a placenta of four and a half months would look. Dr. Adolphi mentions a few similar cases found in the literature, and thought that the true cause of such a retention *in utero* lies in an exceedingly small excitability of the activity of labor pains. —*St. Petersburger Medizinische Wochenschrift, 7-99.*

CAUSE OF INJURIES DUE TO X-RAYS.—Much has been said about serious injuries received in some cases by persons subjected to the X-ray for surgical purposes. These have occasionally suffered from a skin affection resembling acute sunburn, with inflammation, hardening and falling off of the skin, and loss of hair. In a few cases suit has been brought by the victim against the surgeon at whose hands he has received the injury. According to recent researches by Messrs. Bordier and Salvador, the trouble is not due to the X-rays themselves, but to a high tension induction current formed in the near vicinity of a Crookes tube. Their experiments clearly reveal the existence of such a current.

Says the *Revue Scientifique*, July 1: "The researches were undertaken with the aim of furnishing a scientific explanation of the injuries to the skin produced in certain conditions by the Roentgen rays. The two electricians tried to see whether they could not trace these to electrolytic action, due to an induced discharge near the electrodes of the Crookes tube, which discharge passes through the surface exposed to the rays when it is too near. The conclusion to which they have come is as follows: Electrolytic phenomena arise in any electrolyte whose electrodes are situated in the neighborhood of an active Crookes tube. The polarization of the electrodes is not due to the action of the X-rays, but to an obscure induction discharge; this is equivalent to a constant current of high pressure but feeble intensity formed in the neighboring electrolyte."—*The Literary Digest.*

The subject of the use of the Roentgen ray is discussed more nearly from a surgical standpoint on a previous page of this issue.

SUPPURATION OF THE SUBMAXILLARY GLAND IN CONSEQUENCE OF THE DISPLACEMENT OF ITS EXCRETORY DUCT, CAUSED BY A SALIVARY STONE.—In the *Deutsche Medizinal Zeitung* of December 8, 1898, we find an interesting item under the above title by Dr. Burwinkel, of Zabern, in the Palatinate (Bavaria).

All of this
is not active
after

A young baker, aged 18, consulted Dr. B. on November 12 last, stating that since several days he had felt considerable tension and a sort of tumor in the left maxillary angle, each time that he was taking a meal. The tumor increased daily and became more painful. In masticating a solid morsel he also felt pain at the fundus of the mouth cavity, to the left of the *frenum linguæ.*

The mucous membrane of the mouth began to swell, bad taste set in, and horripilation, which induced him to seek medical advice. On examination Dr. B. found the submaxillary gland swollen to the extent of a hen's egg. On touching the gland he felt it hard and painful and the covering membrane was hot.

The mucous membrane at the fundus of the cavity of the mouth was swollen likewise, and to the left of the *frenum linguæ* was a covering of a pale yellow color. There were no carious teeth. Dr. Burwinkel ordered a borated mouth-wash, and poultices to the gland. The following day, patient returned, stating that the ulcer in his mouth had burst after a small stone had been discharged. The concretion, or stone, was of a grayish-yellow color and of a rather rough surface, about one-eighth *m. m.* long and three *m. m.* in diameter, and of an oval form. On examining the mouth the doctor found the opening of the *ductus Whartonianus* gaping on the left side, so that he could easily probe it and reach the submaxillary gland. External pressure on the gland caused pus to issue beside the probe. From that time all symptoms retrograded.

This was the first time Dr. Burwinkel had had a chance to handle a salivary stone, or concretion, though he remembers distinctly having had several times before his eyes the general view of the symptoms of the disease. Evidently the concretion had occluded the gland, which caused its swelling at meal-times. Later on suppuration set in.

HAMBURG MEDICAL ASSOCIATION.—In the supplement of the "*Deutsche Medizinische Wochenschrift*" of January 5, 1899, we notice, in a recent sitting of the above medical association, some very interesting cases:

1. Dr. C. Lauenstein presented a *77-year-old female patient with a completely healed fracture of neck of femur.* Patient had been sent to the Hamburg hospital Bethesda, with the above mentioned

complaint, and was treated according to the maxims laid down by Brünninghausen in Würzburg 100 years ago, only somewhat modified by Lauenstein. Three months afterward she was discharged, with a leg completely useful and a movable hip-joint, and able to walk without the aid of a stick. Lauenstein presented the actinogram, which shows the bony-healed fracture in the middle of the neck, between the head of the femur and the *trochanter major*, and in an oblique direction toward the neck.

Dr. Lauenstein also showed the Roentgen picture of another healed fracture of neck of femur of a female patient 83 years of age, who could not be presented to the association, suffering just then from bronchitis. This patient, too, was treated similarly to the first. She was admitted June 29 of last year in the Hospital Bethesda. On September 1, patient was able to walk alone and without showing lameness. The actinogram showed the healed bony fracture near the head of the femur. The neck of femur is slightly shortened, and very likely will remain so, chiefly on account of the advanced age of the patient. Lauenstein insists that such good results can only be obtained if the sufferers are sent to the hospital the very first day of the accident.

Dr. Alsberg presented a patient where the *Roentgen photography had indicated the diagnosis of kidney-stones.* The finding at the operation showed a complete analogy with the Roentgen picture. Stones and pictures were demonstrated.

Alsberg demonstrated also *an extirpated kidney in a 59-year-old patient*, which had been removed the previous day. The kidney was transformed into a tumor of the size of a child's head and showed the characteristic picture of malignancy of kidney-struma. The stones had a very thin mantle of uric salts and showed blood clots in the interior.

EXTIRPATION OF THE WHOLE GENITO-URINARY APPARATUS.—The Belgian professor, von Winivarter, at the University of Luttish, removed the whole genitals in a man suffering from carcinoma of the bladder, the prostate, urethra and spermatic vesicles being co-affected and involved. The total extirpation of the bladder, the prostate, the seminal vesicles, the whole urethra, the penis, the scrotum and its contents, all the genitals in fact, took place without any accident. Five weeks after the operation patient was quite well again, with the exception of a small fistula.—*Deutsche Medizininal Zeitung, Dec., 1898.*

Rustic.—"These queer new-fangled names that they get up for summer drinks confuse the country folks," said the clerk at the soda fountain, "and, honestly, I don't much wonder. A man carrying a big, old-fashioned valise came wandering in here the other day at the hottest part of the afternoon, and sat down by the corner. He pulled out a red bandana handkerchief, and while he was mopping his forehead he looked the place over from top to bottom. I could see he was trying to make up his mind what he could get the most of for his money, so I said nothing and waited for his order. Pretty soon he noticed that sign hanging on the corner of the fountain: 'Fresh vaccine received daily.' 'Is that there vax-een fresh?' he asked. 'Yes, sir;' says I, thinking he must be a country doctor. 'Got it in to-day?' 'Yes, sir;' I said, 'just arrived.' He thought for quite a while and then he suddenly pulled out his pocket-book. 'Oh, well,' he said, 'I reckon y' kin gimme a glass.'" —*Times-Democrat.*

The Health of Italy.—Even as the rise of the Nile in Lower Egypt is awaited with mingled hope and misgiving, so the wave of travel is expected in the Italian winter cities and "sun-traps." The streets of the chief health resorts show signs of preparation for the coming guests. They are swept and cleaned while shopkeepers are laying in a supply of stores. All the signs of welcome pale before the attractive power of the improved health returns just issued by the Minister of the Interior, showing the good already fructifying from the regulations imposed requiring monthly health bulletins from each district. The prefects of each district in turn serve these to the Minister of the Interior, together with an estimate of the health conditions of the community. The detail work is done by the commercial (or district) practitioners, so that the statistics are fairly trustworthy and the prevalence of disease and the mortality rate can be estimated. The prevailing infectious diseases in Italy are typhoid, diphtheria, or "difterite," as the Italians call it, and scarlet fever, occurring in the order named. Altogether the health of the kingdom is good.—*Lancet*, Lond.

THE MORAL IMBECILITY OF A NATION.—The editor of the *Philadelphia Medical Journal* expresses himself thus on the outcome of the Dreyfus case: "That disease, and especially disease of a psychic kind, may affect an entire nation, is not a new truth, but the hideous fact is sickeningly illustrated by the France of to-day. Slavery of the most brutal and heathenish kind is the lot of nearly every soldier forced into the army—a slavery reeking with malicious cruelty and utter disregard of manliness and decency. Sexual diabolism is so fashionable, and hatred of the Jews reaches such a fury, that these things would be ludicrous if they were not tragically morbid. A few honorable men in the hell of dishonor look impotently and sadly about them seeking for a humane face, a healthy mind or an upright character in this insane national mob, howling its lunatic hatred of one innocent victim, and forgetting its own putrescent crime in the old scapegoat frenzy of mania. As there is not a national madhouse or pesthouse, the civilized races should put France into Coventry, until death from her own gangrene shall have relieved humanity of our greatest disgrace. Let her and her ghastly militarism go the way of Nero's Rome, her ancient prototype, in crapulous infamy."

THE EDITOR of the *American Practitioner and News*, in speaking of the kissing bug, says: "In the beginning, it is to be understood that there is no such an insect in existence. That people have been bitten on the lip and about the mouth by insects of one kind or another there can be no doubt, and it is equally true that these happenings are not new; but the only kissing thing to be dreaded is the biped with a chancre on its lip or a tubercular cavity in its lung."

THE DESTRUCTION OF MOSQUITOES.—Elaborate experiments are now being performed in Rome by Prof. A. Celli and others to determine the best method of killing mosquitoes. The Italian government hopes thus to largely diminish the amount of malaria in the metropolis.

REMARKABLE DIVORCE SUIT.—A rather rare and remarkable divorce suit is now pending in a Paris court. A wife brings suit against her husband because he became pregnant and brought forth a child at full term. Investigation proved the supposed husband to be a female hermaphrodite.—*Philadelphia Medical Journal.*

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Manual of Diseases of the Nervous System. By SIR W. R. GOWERS, M. D., F. R. C. P., F. R. S. Revised and enlarged. Edited by Sir W. R. GOWERS and JAMES TAYLOR, M. A., M. D., F. R. C. P. Volume 1, Diseases of the Nerves and Spinal Cord. With 192 illustrations. P. Blakiston's Son & Co., Philadelphia.

This enlarged edition of Dr. Gowers' is a welcome addition to our libraries. It is very much enlarged over the previous edition, and is certainly the best work on Diseases of the Nervous System in the English language. Volume 1. treats of the diseases of the nerves and of the spinal cord.

P. E. A.

Lectures on the Malarial Fevers. BY WILLIAM SIDNEY THAYER, M. D. Associate Professor of Medicine in the Johns Hopkins University. D. Appleton and Company, New York.

Next to Laveran's original work, *Traité des fièvres palustres*, 1884, this book should stand on the desk of every practicing physician. It is the American counterpart of the French scientist's masterly piece of work, therefore, having the advantage over the latter of having appeared at a time when our knowledge of the subject had been greatly amplified. The so-called practical minds who will hear of nothing else but of treatment and positive results may stop here and think over this book to convince themselves of the far-reaching and at the same time fruit-bearing propensities of what is termed science. There are twenty-one substantial pages on treatment, and they alone should commend the book, for they are worth reading and safe-keeping. As for the book itself, in its material form, it is a credit to the publisher.

DUPAQUIER.

The Mineral Waters of the United States and Their Therapeutic Uses, by JAMES K. CROOK, A. M., M. D., Lea Bros. & Co., New York and Philadelphia, 1899.

The medical profession owes Dr. Crook a great deal for the compilation of the material contained in the pages of this book. It fills a long felt want. A great deal of care has been exercised in gathering exact information from every available source. Nearly 500 pages are devoted to the description of the mineral springs and other waters found in each State of the Union. The most recent analyses are given and a suggestion of the therapeutic use of every water where such is indicated.

The author begins by reviewing the histories of mineral waters and their uses internally and externally. He considers the several classifications of mineral waters, and suggests a practical classification of his own. The chapters following discuss mineral waters generally as to their consistency, therapeutics and the indications of their definite ingredients in certain diseases. Two chapters are devoted to the discussion of baths and douches and their medicinal uses, which, while extraneous, are well written and add to the value of the book.

With such an introduction the author takes each State in alphabetic turn, and reviews the springs, wells and waters of each, likewise in alphabetic order. To indicate how thoroughly this is done, there are 72 pages devoted to the springs of California and even the obscure springs of each State are mentioned where a description is impossible.

An appendix discusses the essentials of potable waters and suggests the methods of testing for pollution.

Altogether the book will meet a demand. the necessity of which is chiefly evidenced by the general and confessed ignorance on the part of the medical profession as to the vast variety of mineral springs this country affords. Dyer.

The American Year Book of Medicine and Surgery—1899.—Edited by Geo. M. Gould, M. D. W. B. Saunders, Philadelphia.

No pains have been spared to make the *Year Book* a complete, comprehensive and valuable review of medicine and surgery for 1897 and 1898. Every field is covered; surgical procedures are related in detail; new remedies are described and all methods of pathologic and bacteriologic advance are instanced. Each department is carefully prepared and edited by men of note and ability. The references to the sources from which information has been obtained are complete. The illustrations are plentiful and perfect. The work must stand for all time as a valuable cyclopedia of current medical and surgical knowledge.

Dyer.

A System of Medicine by Many Writers. Vol. VI. Diseases of the Circulatory and Nervous Systems. Edited by Thomas Clifford Allbutt, M. A., M. D., LL. D., F. R. C. P., etc. The McMillan Company, New York, 1899.

The entire relegation of consideration of space as secondary to substance makes this system the best of its kind. Every article is a complete monograph full of discussion and broad in its handling. It would require a nicety of discrimination to make any selection among the articles in the present volume as standing out by comparison. It is interesting to note that Professor Welch, of Johns Hopkins, has contributed to the subject of embolism and thrombosis, both articles being thoroughly comprehensive and replete with the characteristic details of each subject.

The apparent intention of the editor to consider all subjects in medical branches within the same broad lines make the system *sui generis*. In no other work has so liberal a handling been evidenced. Subjects usually dismissed in a few lines, or in a page or two, in this work find exhaustive discussion and relation.

DYER.

Electro-Hæmostosis in Operative Surgery. By ALEXANDER J. C. SKENE, M. D., LL. D. D. Appleton & Co., New York, 1899.

This book is in reality a continuation of the subject only mentioned in the doctor's recent work on Gynecology. In this book electro-hemostosis is treated most elaborately. The whole question is practically and scientifically presented, and the various operative steps clearly brought out with clear illustrations.

The only question remaining is that of the practical application of the principle advanced, which application, owing to the electrical and technical knowledge required, will hardly prove popular. The reviewer has made several experiments with the forceps and must say that thus far he has been discouraged. However, he will continue his experiments and will, later on, publish the results.

The book, nevertheless, is so full of valuable information concerning post-operative hemorrhage, etc., that it should be carefully read by every surgeon.

MICHINARD.

American Text-book of Disases of the Eye, Ear, Nose and Throat. Edited by G. E. DESCHWEINITZ, A. M., M. D., and B. ALEX. RANDALL, M. A., M. D., PH. D. Published by W. B. Saunders, Philadelphia.

The text is composed of contributions from the pens of a number of well-known American writers who have been assigned by the editors each to that particular subject to which he has devoted special attention.

The volume is richly illustrated with schematic drawings, photogravures and colored plates, containing in all 766 engravings, which constitute not the least important feature of a book of this kind. As must necessarily follow in the compilation of a work covering such a large field in the special branches, the space allowed each author is limited, and this accounts for the brevity with which some of the subjects are treated; withal, however, it is quite a complete treatise, and offers the latest theories and the most generally approved methods of therapeutics. It is excellent as a reference and text-book, and well worthy of a prominent place in the series of text-books from the same publisher. DEROALDES & KING.

The Newer Remedies, including their Synonyms, Source, Methods of Preparation, Tests, Solubilities, Incompatibles, Medicinal properties and Doses as far as known, together with Sections on Organo-Therapeutic Agents and Different Compounds of Iron. A Reference Manual for Physicians, Pharmacists and Students. By VIRGIN COBLENTZ, A. M., Phar M., Ph. D., F. C. S., etc. Third Edition. P. Blakiston's Son & Co., Philadelphia, 1899.

This small volume will prove of much value to the physician and pharmacist, as many drugs here described are not referred to in text-books. The original orthography of all titles has been retained, excepting in cases in which a foreign manufacturer has made a slight change for the benefit of our market—as, for example, in eucaine and antipyrine, where a terminal "e" has been added. In all other cases the author has adopted as far as possible the rules of chemic orthography as sanctioned by the A. A. A. S. in 1891.

The composition of all proprietary combinations is given according to published analyses. Wherever possible, among the patented synthetics, the author has endeavored to include the name of the patentees. The fact that this is the third edition since 1895 is sufficient evidence that the profession appreciate the work. STORCK.

A Text Book of Pharmacology and Therapeutics, or the Action of Drugs in Health and Disease: BY ARTHUR R. CUSHNY, M. A., M. D. Aberd. Illustrated. Lea Brothers & Co., Philadelphia, 1899.

This work is modeled after the classic work of Schmiedberg. No physician can fail to appreciate the manner in which the different subjects are presented. A bibliography is appended to each chapter. The author says: "My object has been to bridge over the hiatus which exists between the phenomena occurring in the normal organism and those which are elicited in the therapeutic use of drugs, to show how far the clinic effect of remedies may be explained by their action on the normal body, and how these may in turn be correlated with physiologic phenomena.

"It necessarily follows that the subject is treated from the experimental standpoint, and that the results of the laboratory investigator are made the basis of almost every statement. Where these fail to elucidate the therapeutic effects or even to suggest a possible explanation, I have preferred to leave the question undiscussed rather than to call on such occult *dei ex machina* as alterative or tonik actions.

"There is still a tendency even among the educated to ascribe therapeutic virtues to every new weed and every new product of chemic industry and the teacher of pharmacology must not only point out the good, but has the most ungrateful task of condemning the worthless. The period of constructive pharmacology has scarcely dawned; at present its chief function is destructive and critical."

Particular attention is given to the preparations of the United States and the British Pharmacopeias, small capitals being used for those more generally used. It is a model of a text-book. Even its style gives the impression of rigid accuracy, of plentitude of knowledge, of careful revision.

STORCK.

A Manual of Organic Materia Medica. Being a guide to Materia Medica of the Vegetable and Animal Kingdom, for the Use of Students, Druggists, Pharmacists and Physicians. By JOHN M. MAISCH Ph. M., Phar. D. Seventh Edition. Revised by HENRY C. C. MAISCH, Ph. G., Ph. D. Copiously Illustrated. Lea Brothers & Co., Philadelphia, 1899.

We have always considered this work the best of its kind written by an American author. It will prove of great value to the student of pharmacy, as it is a most excellent summary of materia medica from a botanic point of view.

All recent advances in the pharmacognostic and chemical study of drugs have been introduced, and the work brought up to our present standard.

STORCK.

Louisiana State Board of Health—The Sanitary Code, 1899. EDMOND SOUCHON, M. D., President.

Dr. Souchon has gone to some pains to present the laws and rules regarding the public Health of the State of Louisiana. In some 400 pages the Sanitary Code takes up all the State regulations, Federal regulations and local laws directed at Quarantine, Sanitation, Pure Food, etc. The laws concerning leprosy are included. The last chapter is devoted to the "Atlanta Regulations." For this particular field the book is valuable as a reference.

Mammalian Anatomy. A Preparation for Human and Comparative Anatomy. By HORACE JAYME, M. D., Ph. D., Director of the Wistar Institute of Anatomy and Biology, Professor of Zoology, University Pennsylvania, etc. Over 500 original illustrations. J. B. Lippincott Co., Philadelphia, 1899.

This volume represents a large and painstaking labor, which is presented in an attractive and readable form. The subject is elaborately treated, and will be a valuable book to those interested in the subject.

FRIEDRICHS, M. D.

Hay Fever and its Successful Treatment. By W. C. HOLLOPETER, A. M., M. D., Second Edition, Revised and Enlarged. Philadelphia, P. Blakiston's Son & Co., 1899.

Dr. Hollopeter's manual is both instructive and interesting, everything of importance concerning hay fever can be found within its covers. The doctor claims that nearly all cases of hay fever can be cured. The addition of a complete bibliography adds value to the book.

STORCK.

A Text-book of Mechano-Therapy (Massage and Medical Gymnastics), by AXEL B. GRAFSTROM, B. SC., M. D. W. B. Saunders, Philadelphia, 1899.

A large amount of material is condensed in this little book, which presents the subject of massage and medical gymnastics in a practical way. The definitions are unusually clear and the few illustrations are carefully selected. DYER.

The Philosophy of Memory and Other Essays. By D. T. SMITH, M. D., Lecturer on Medical Jurisprudence in the University of Louisville. John P. Morton & Co., Louisville, 1899.

A series of philosophic studies, full of thoughtful study and preparation on the part of the author. The collection is worth reading.

The International Medical Annual and Practitioner's Index. Seventeenth year, 1899. E. B. Treat & Co., New York and Chicago.

This edition contains a mass of information arranged alphabetically, giving a review of every branch of medical science. The material has been carefully edited by a list of able contributors. The publishers have spared no pains in making this volume comprehensive. DYER.

International Clinics. A Quarterly of Clinical Lectures. Edited by JUDSON DALAND, M. D. Vol. I and II, Ninth Series, 1899. J. B. Lippincott Co., Philadelphia.

Among the usual interesting series of articles published in these volumes, the present number contains several of particular note. Of these the articles on the Care and Treatment of Phthisical Patients, the Treatment of Burns, the Operative Treatment of Hemorrhoids, the Frequency of Cases of Unsuspected Syphilis and the Lecture on Lupus Vulgaris are noteworthy. DYER.

Massage and the Swedish Movements. By KURRE W. OSTROM, from the Royal University of Upsala, Sweden. Fourth Edition. P. Blakiston's Sons & Co., Philaelphia, 1899.

The merit of this little book is evidenced by the demand for a fourth edition. The detail of the subject matter is especially clear. The section on the Swedish Movements is profusely illustrated in a practical and comprehensible manner, so that the average reader could easily use the book as a guide. A list of diseases is given, in which the methods instanced are of service and their application is outlined. An excellent bibliography on these subjects is appended. DYER.

Practical Diagnosis. By HOBART AMORY HARE, M. D., B. SC., Professor of Therapeutics, Jefferson Medical College, Philadelphia. Fourth Edition. Revised and Enlarged. Lea Bros. & Co., Philadelphia and New York, 1899.

This is essentially a practical work, in the original conception of which the author has shown a due appreciation of the fact that, however much science may do to apply methods of precision to the diagnosis of disease, the main reliance of the average physician is, after all, the study of obvious symptoms.

"The Use of Symptoms in the Diagnosis of Disease," as set forth on the title page, is the key note of the work, and in addition to a comprehensive, logical and lucid review of this subject, as applied to the whole domain of medicine, Professor Hare places before his readers in concise and practical form all the modern and scientific aids to diagnosis.

Such a work brings to the physician in remote fields of labor, the crystallized experience of the ablest clinicians of the day, interpreted by one who is himself an eminent teacher in one of the world's centers of medical learning.

The book contains more than 600 pages. and in press-work and illustrations is worthy of its author and publishers.

PATTON.

Mechanics of Surgery. By CHAS. TRUAX, Chicago, 1899.

The *Mechanics of Surgery* is the first book of its kind and will unquestionably grow in popularity, as it contains all the information any surgeon could desire in regard to the care, constructoin and use of instruments. The style is easy and comprehensive. It treats not only of such subjects as stated above, but gives many practical suggestions that can not fail to prove of interest and value. It is an addition to any surgeon's library.

MARTIN.

Human Anatomy. A complete systematic treatise by various authors, including a special section on surgical and topographical anatomy. Edited by HENRY MORRIS. Illustrated by 790 woodcuts, over 200 in colors. Second edition, revised and enlarged. Philadelphia, P. Blakiston's Son & Co., 1898.

The aim of the editor was to make this work complete as "a systematic description of every part and organ of the human body as it is studied in the dissecting-room." "Minute anatomy must be studied, of course, but in the histological laboratory; not in the dissecting room, or at the demonstrator's classes on topographical anatomy." We think this the correct view. The work as a whole is the equal at least of any work on anatomy with which we are familiar, and being just revised is up-to-date, a not insignificant recommendation, when we consider the progress made in recent years in the methods of anatomical teaching. A most valuable section is that by Jacobson on surgical and topographical anatomy. A short section on vestigial and abnormal structures closes the book. We can heartily recommend the book to students and practitioners of medicine.

P.

A Text Book of Anatomy. By American Authors. Edited by FREDERIC HENRY GERRISH. Illustrated with 950 Engravings, in Black and Colors. Lea Bros. & Co., Philadelphia and New York, 1899.

This book on anatomy will, we believe, be welcomed by both students and practitioners of medicine. The discussion of microscopic anatomy and of embryology might, in our opinion, have been omitted with advantage, since there are special treatises on these subjects quite accessible to students, and these studies being necessarily carried on elsewhere, they uselessly increase the size of a book which must be used in the dissecting room. There is much to commend the book and very little to find fault with. The illustrations are especially happy and will greatly assist in preparing to make a dissection. The sections on Relational Anatomy are useful additions. This includes Plane Sections. Surface Anatomy and Normal Skiographs. The work is altogether a credit to American medicine.

P.

PUBLICATIONS RECEIVED.

The American Pocket Medical Dictionary, edited by W. A. N. Dorland, M. D.—W. B. Saunders, Philadelphia, 1899.

The Treatment of Pelvic Inflammation Through the Vagina, by William R. Pryor, M. D.—W. B. Saunders, Philadelphia, 1899.

The Hygiene of Transmissible Diseases, by A. C. Abbott, M. D.—W. B. Saunders, Philadelphia, 1899.

Practical Anatomy, edited by W. T. Eckley, M. D., and Mrs. C. B. Eckley.—P. Blakiston's Son & Co., Philadelphia, 1899.

Diseases of the Nose and Throat, by D. Braden Kyle, M. D.—W. B. Saunders, Philadelphia, 1899.

Transactions of the Medical Society of the State of West Virginia, 1899.

Transactions of the Medical Society of the State of New York, 1899.

Index Catalogue of the Library of the Surgeon-General's Office, United States Army, Second Series, Vol. IV, Washington, 1899.

not taken

Johns Hopkins' Hospital Reports, Vol. VII, Nos. 5, 6, 7, 8, 9, Baltimore, 1899.

Ninth Annual Report of the Eye, Ear, Nose and Throat Hospital, 1898, New Orleans, La.

Manual of the Medical Guild of the Misericordia.

College Announcements—New York University, The University and Bellevue Hospital Medical College, Northwestern University, Woman's Medical School, Chicago, Annuaire de l'Ecole de Medicine et de Chirurgie De Montreal.

Minor Surgery and Bandaging, Henry R. Wharton, M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

Enlargement of the Prostate, Its Treatment and Radical Cure, by C. Mansell Moullin, M. D.—H. K. Lewis, London; and P. Blakiston's Son & Co., Philadelphia.

Diseases of the Eye—Quiz Compend, by George M. Gould, A. M., M. D., and Walter L. Pyle, A. M., M. D.—P. Blakiston's Son & Co., Philadelphia.

Diseases of the Nose and Throat, by Cornelius G. Coakley, M. D.—Lea Bros. & Co.

A Compend of the Practice of Medecine, Daniel E. Hughes, M. D.—P. Blackiston's Son & Co., Philadelphia.

REPRINTS.

Gastro-Enterostomy. By Byron B. Davis, M. D.

Advice to Gonorrheal Patients. By Ferd. C. Valentine, M. D.

The Evolution of the Modern Therapy. By Simon Baruch, M. D.

One Hundred and Sixty-six Cases of Cancer of the Pregnant Uterus Occurring Since 1886. By George H. Noble, M. D.

Historique Des Applications Pratiques De La Phonetique Experimentale—Paris.

Some Remarks on Chronic Bright's Disease, by Arthur R. Elliott, M. D.

Chronic Interstitial Nephritis—Treatment of the Heart Therein, by Arthur R. Elliot, M. D.

De la Variocele—Sa Cure Radical par la Ligature Double et L'excision des veines combinées a la Résection étendue du Scrotum, par M. le Dr. M. T. Brennan.

Certains Troubles Vocaux—Note Sur le Traitement des Aphonies et Dysphonies Nerveuses, par M. le Dr. Paul Olivier.

Historique des Applications Pratiques de la Phonetique Experimentale, par M. l'Abbé Rousselot.

Nephro-Ureterectomy for Traumatic Hæmato-Hydro-Nephro-Ureterosis, by J. E. Summers, Jr., M. D.

Antiphthisic Serum, T. R. in Tuberculosis, by A. Mansfield Holmes, A. M., M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR AUGUST, 1899.

CAUSE.	*White*	*Colored*	*Tot.*
Fever, Malarial (unclassified)	2	6	8
“ “ Intermittent		1	1
“ “ Remittent	1		1
“ “ Congestive	6	4	10
“ “ Typho	4	3	7
“ Yellow			
“ Typhoid or Enteric	8	7	15
“ Puerperal			
Influenza			
Measles		1	1
Diphtheria			
Whooping Cough		2	2
Apoplexy	8	1	9
Congestion of Brain	10	4	14
Meningitis	10		10
Pneumonia	6	3	9
Bronchitis	5	5	10
Cancer	12	1	13
Consumption	28	31	59
Bright's Disease (Nephritis)	27	19	46
Uremia		2	2
Diarrhea (Enteritis)	13	6	19
Gastro-Enteritis	4		4
Dysentery	4	3	7
Hepatitis	3	1	4
Hepatic Cirrhosis	5	2	7
Peritonitis	6	1	7
Debility, General	3	5	8
“ Senile	13	8	21
“ Infantile		3	3
Heart, Diseases of	23	12	35
Tetanus, Idiopathic			
“ Traumatic	6	1	7
Trismus Nascentium	7	8	15
Injuries	12	13	25
Suicide	2		2
All Other Causes	107	44	151
TOTAL	335	197	532

Still-born Children—White, 30; colored, 19; total, 49.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 19.19; colored, 26.26; total, 21.27.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	29.95
Mean temperature	84.00
Total precipitation	2.31 inches

Prevailing direction of wind, southwest.

NEW ORLEANS
MEDICAL AND SURGICAL
JOURNAL.

VOL. LII. NOVEMBER, 1899. No. 5.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

NEURILITY—IS IT A VIBRATORY MOTION?

BY RALPH HOPKINS, A. B., M. D., NEW ORLEANS, LA.

Although but little is known of neurility, on account of the great difficulty in conducting experiments to ascertain its nature, yet the theory at present accepted in regard to the essential nature of the great forces, heat, light, electricity and magnetism, suggests that the neural impulse, by virtue of its close analogy to electricity, may also be a form of vibratory motion. This analogy seems to hold good as to the manner of its generation and conduction, and its method of final disposal.

In regard to the generation of neurility, though we find currents traveling both to and from the cerebrum, yet the nerve impulse is produced only in the cells, the fibers being mere conductors.

Of the cells generating the neural impulse the most important are, of course, those found in the cerebral and spinal gray matter. It is in the functioning of these cells that there exists a striking analogy to the production of an electric current.

As in the simple voltaic cell, composed of strips of zinc and copper, immersed in water acidulated with sulphuric acid, no current is produced nor chemic action effected until the zinc and copper be united by a wire; so, also, we may suppose that the nerve cells, though bathed in the oxidizing serum of the blood, generate no force nor undergo any chemic change, until in some mysterious way the necessary connection be effected, when immediately combustion takes place and the energy thus liberated, as in the case of the voltaic cell, is transmitted through the conducting media as a vibratory motion. It seems entirely rational to suppose that the energy derived from chemic action should display itself in a vibratory molecular motion, because of the very nature of this action, which means the tearing asunder of old molecules, and the rushing together of the liberated atoms to form new molecules—a very vortex of atomic motion; added to which we have the special adaptability of the axis cylinders to receive and transmit vibrations. Moreover the hypothesis that some connection must be made in order to complete the circuit, so as to permit the generation of the force, offers an explanation for the presence of the dendra found attached to the cells, whose function may be to assist in the closing of the circuit.

Besides the efferent neural impulse there is also the afferent, which telegraphs messages from the five senses and also the impressions of common sensation. Of the senses there is one whose terminal nerve filaments are directly stimulated by vibrations, viz; audition. Whether or not the beautiful theory of Helmholtz, as to the function of the rods of Corti, be true in the sense that each rod is attuned to vibrate in consonance with a note of an equal number of vibrations per second, yet the fact is generally admitted that these rods are thrown into vibration by musical notes and noises. And it seems reasonable to suppose that this stimulus, commenced in the termini of the auditory nerve as a vibration, is continued as such throughout the length of the nerve to the centre capable of receiving and interpreting it. Moreover if, as Hensen objects to Helmholtz's theory, it be impossible for the rods of Corti, on account of their anatomic position, to vibrate each one separately, there remains no other explanation of the mechanism of the appreciation of the pitch of notes, except that the axis cylinders themselves, throughout the length of the auditory nerve, are capable of vibrating with varying degrees of rapidity in unison with notes of different pitch.

The mechanism of vision is more complex. In the ear nature has only to devise a mechanism by which the vibrations of the air are taken up and transmitted by a solid—a function admirably performed by the membrana tympani. But in the eye, the vibrations that are to be taken up are of an imponderable substance that permeates all matter, so light and elusive that it has even defied all attempts to positively demonstrate its existence. It would evidently be absurd to suppose that the rods and cones of the retina, be they ever so delicate, are capable of vibrating in consonance with so fluid a substance. Moreover the same objection would here obtain, as against the theory of Helmholtz, that is, their inability to vibrate separately on account of their anatomic proximity. The most probable explanation of this complex mechanism is suggested by the presence of the visual purple, which indicates by its change of color that some chemic action takes place in the retina, under the action of lights of different intensity. But, as the visual purple does not exist in the fovea centralis, it is evident that we must look elsewhere for the seat of this chemic change produced by the images thrown upon the retina. It is well known that the actinic solar rays are capable of inducing chemic action between elements that remained uncombined, until exposed to their actions; and so it may happen in the retinal rods and cones that a chemic action takes place under the influence of light, in direct proportion to the rapidity of vibration of the luminiferous ether. In other words, for each of the colors of the spectrum there would be a corresponding definite amount of chemic action. And given a chemic action in the rods and cones, there follows the possibility of the generation of a vibratory motion, the rapidity of the vibrations being proportional to the amount of chemic action. That this current must be exceedingly weak is manifest from the inconsiderable chemic action that could possibly take place. So for its reinforcement we find the ganglion cells of the retina that are probably stimulated by this feeble current to the discharge of a far greater amount of energy, giving vibrations of sufficient amplitude to reach the sight centres.

In illustration: Suppose an image cast upon the retina to be half red and half violet, the violet rays would vibrate the more rapidly and cause a greater amount of chemic action in the rods and cones upon which they fall, which sends a stronger current to the cells of the retina, which in their turn are stimulated to discharge through the optic nerve a neural current more rapid in its vibrations than that produced by the red, so that finally we would find every axis cylinder of the optic nerve vibrating with a degree of rapidity proportional to the rapidity of vibration of the color of that part of the image thrown upon the rod or cone with which it is connected. Further than this there is only the inexplicable final interpretation of the impulse by consciousness, about which it is impossible even to theorize. It may seem strange, even in theory, to turn the retina into a chemic laboratory; but, when we consider that the nearest approach to the explanation of life itself lies in chemic action, it is not so astonishing that the functioning of an organ should depend upon the same principle. The experiment first performed by Ritter of passing an electric current through the eye is in support of the theory that sight impressions are conveyed as a vibratory motion through the optic nerve. A weak current produced the sensation of a flash of light, and a strong current gave the impression of blue and green waves flowing before the eyes, the latter part of the experiment being in support also of the theory that varying vibrations of the optic nerve are translated by consciousness as colors.

To devise a theory for the explanation of the mechanism of taste it becomes necessary to have recourse to some great principle of chemic action generating a neural impulse. Granted this, and also the fact that the axis cylinders of the gustatory and corda tympani nerves are capable of vibrating more or less rapidly, and the explanation is patent. The sapid substance, if not already in solution, is dissolved by the salivary juice, comes in contact with the papillae of the tongue, and passes through the taste pores, when it comes in contact with the taste cells of the taste beakers. Here chemic action takes place and so the impulse is generated. To explain the fact of the different taste of different substances we may borrow the theory of Helmholtz, giving to certain cells an affinity for certain substances only. But it seems more probable that all the cells are acted on together, but that the nature of the chemic action being different for different substances, the resulting vibrations vary in their rapidity. In support of the theory that taste impressions are conveyed to their centres as a vibratory motion, is the fact that stimulation of the tongue by an electric current (which is a vibratory motion) produces a decided taste. The probability of a chemic action in the taste cells is strengthened by the fact that the salts of such elements as chlorin and bromin, which have nearly the same chemic affinities, have similar taste; also, by the fact that after prolonged contact with strongly sapid substances, the sense of taste is benumbed, which is readily explained on the ground that the combining element of the cells has become exhausted, arresting all further chemic change. Applying this principle also to the retina, involuntary winking is explained by the necessity for the reforming of the combining element, though in the retina this element is probably refurnished more rapidly than in the taste cells.

The explanation of the mechanism of olfaction is identical with that for taste, except that the emanations from odorous substances being gaseous, the olfactory apparatus is more delicately adjusted than the gustatory, and has a wider range of vibration to differentiate between the more numerous different odors that it is called upon to appreciate.

In touch and the sensation of tickling we have a vibratory motion directly communicated to the tactile corpuscles, Pacinian bodies, or other end bulbs, by the shock of contact or by friction. The sensation of tickling is produced in unexposed surfaces where there is no excessive epidermal formation to protect the end bulbs, which are exposed to a too violent stimulation, which seems to be due more to the rapidity of the vibrations than to their amplitude, as it depends on a light and rapid touching motion rather on a forcible one. To best exercise the sense of touch, we mechanically and almost involuntarily freely move the fingers over the body to be examined, as the vibratory motion is not well communicated to the nerve endings by one single shock, but rather by a continued motion, as is well shown by the fact that we become insensible to the impressions of touch when an object remains in mere quiescent contact with the tactile corpuscles. The idea intended to be conveyed is that the nerve terminations are thrown into vibration in very much the same way as a bell that is struck or a violin string across which the bow is drawn.

The sense of heat is easily explained on the same hypothesis of molecular vibratory motion (the theory of heat); the intensity of the impression depending, as the heat of the body itself, upon the amplitude and rapidity of the vibrations of the constituent molecules. Cold is probably merely the absence of the normal amount of vibrations, which the senses have become so accustomed to, that they fail to make any impression, but their absence is immediately appreciated.

Pain, the most reliable and indispensable of nature's warnings of the disregard of her laws, is generally conceded to be due merely to over stimulation or over vibration of the nerve fibers, which may be caused by heat, blows, pressure, chemicals, etc., all of which are capable of transmitting very violent vibratory waves.

In considering the methods of termination (or rather the beginning) of the different fibers of the five senses, we find that two do not begin in cells, and it is remarkable that these two are the ones whose terminal filaments are directly thrown into vibration without the intervention of chemic action. It seems that the vibrations produced in the termini of the auditory nerves and the nerves of touch are of sufficient strength to carry to the brain, whereas the weaker currents produced by chemic action in the retina, Schneiderian mucous membrane and taste beakers, require the reinforcement of relays of energy-producing cells to enable them to reach their destination.

As to the conduction of the neural impulse, the supposition is natural that, as the axis cylinders of the nerve fibers are all identical in structure, so far as may be discovered by even the most powerful microscopes, so also they have similar functions, viz.: the conduction solely of vibrations.

We find throughout the economy nerve fibers of two great classes, the medullated and non-medullated. The function of the medulla is to act as an insulator to prevent the dissipation of the nerve force, with the same object for which electric wires are wrapped in some non-conducting material. The neurilemma is merely a protecting sheath for the axis cylinder and its medulla, found in exposed situations. The non-medullated fibers are found in the nerve endings where the force is to be dissipated, and at the nerve origins in the gray matter. It is in the absence of the insulating medulla from the axis cylinders as they take their origins from the cells, that we are met with an apparent difficulty. Why is it that the energy just acquired is not transmitted in all directions to every cell with which it comes in contact before it acquires its insulation? There can be but one answer: The cells, though capable of generating the neural impulse, are incapable of conducting it, just as electricity can be generated by rubbing glass with silk, both of which are non-conductors. The fact is evident that the cells are incapable of conducting vibrations, when we consider that, were it otherwise owing to their proximity, no one cell could act independently of the others, but that the action of one cell would excite every cell with which it were in contact to a discharge of its energy, with a resulting cranial chaos.

Other points of apparent difference in the conduction of the neural impulse and the electric current, that would seem to militate against the theory of the vibratory nature of the neural impulse, can be shown to be due more to the nature of the conductor than to the current it carries. Although ligation or section of the conductor destroys neurility and not electricity, yet I believe that this is not due to a difference in the essential natures of the two currents, but to the fact that in wires the connection can, after section, readily be re-established by contact, whereas the divided ends of the axis cylinders, the true conducting element of neurility, owing to their delicacy of structure, and a probable shrinkage within the neurilemma after section, can not be brought into contact with each other. Moreover the multiplicity of the axis cylinders, in even the smallest nerve, precludes the possibility of joining each axis cylinder to the end from which it was divided. Besides, the preponderance of the insulating material, medulla and neurilemma, over the conducting material, makes it far more probable that the ends of the axis cylinders, when the establishment of connection is attempted, will be brought into contact with a non-conducting element, rather than with another axis cylinder. This difficulty in bringing the axis cylinders in contact with conducting substances also offers an explanation for the fact that neurility has only one discovered conductor, viz.: nerves; experiments to discover other conductors having probably failed because of lack of contact between the axis cylinders and substances being tested as conductors of neurility. The fact that neurility can select a special conductor, whereas electricity passes to all conductors, may be explained, without having recourse to an hypothesis of a difference in the essential natures of the two impulses, by the fact of the insulation of the nerve conducting element from the centre to where the nerve impulse is destined to be discharged, where the neurilemma and medulla disappear. It is due to this insulation that the impulse must follow the axis cylinder, in exactly the same manner as the bundles of wires, each one insulated, leave the central station of a telephone system, separate and are distributed separately to different houses, each wire always carrying its message over the same route. It is true that the neurilemma is not found in the spinal cord and other protected localities, but this is readily explained on the ground that the medulla is the insulating substance, and the neurilemma, where the nerve is exposed, is merely for the protection of the medulla and the axis cylinder.

The difference of velocity between neurility and electricity, and also the different effects of cold, can be accounted for by a difference in the conductor rather than in the force conducted.

The electric current is known to travel with varying rapidity in different media (Ganot). It is well known also, that sound, a vibratory wave motion, is less rapidly transmitted the more fluid the medium may be. The effect of cold upon the delicately organized axis cylinders is ill compared with its effects upon the metallic conductors of electricity. Heat and cold, in the highly organized organic molecule, have actions far more complex than the simple separation and approximation of the molecules that takes place in the metals under the caloric influence. The chemic balance in the one is so nice that causes which do not affect the other are capable of disturbing its equilibrium. So when we consider that, for the phenomena of life and nutrition, a definite amount of heat is required, it is not astonishing that an absence of heat should retard the functioning of the highest of the tissues, even though, mechanically, we would expect an opposite effect. In the conduction of neurility a familiar electric device is exemplified, the principle of which nature seems to have made use of, namely, the relay system by means of which energy is saved and weak currents are made to carry greater distances, an illustration of the human relay batteries are the ganglia found in various parts of the body, which, situated in the course of nerves, reinforce the currents which pass through them by a discharge of their energy. And it is worthy of observation that ganglia, as it is inaptly said, are always formed at the expense of the sensory roots of nerves, the very fibers that conduct the current that may well be supposed to be the weaker and in most need of reinforcement.

Concerning the methods of final disposal, or the effects produced by the neural impulse, we still find many points of similarity between the two forces that are being compared. There seem to be two principal effects produced by the efferent current, one upon the nutrition of the cells and the other upon muscular tissue. That the cells are dependent for their nutrition not only upon a sufficient supply of pure pabulum, but also upon the energy transmitted to them by the nerves necessary for the conversion of this pabulum into their proper substance, is abundantly proved by the atrophy following in the areas of its distribution, the section of a motor nerve. This force presiding over nutrition, upon which the health and life of every cell depends, may well be regarded as a vibratory motion which shakes apart the old molecule and the atoms composing the molecule, allowing new affinities to supplant the old. We might compare the molecules about to be disintegrated to some tottering tower that the concussion of a single cannon ball is sufficient to precipitate in ruin.

Just how the electric current is able to magnetize a bar of iron we do not know; but we can not fail to see an analogy between this phenomenon and the effect of the discharge of neural energy in muscular tissue. In both cases the effect is to cause attraction, which in the elastic muscular fibers causes a considerable shortening in their length. The development of muscles under the influence of exercise may be due directly to the stimulation to nutrition that the cells receive by the discharge of the same impulse that causes the contraction of the muscles. Another method of the disposal of the efferent current is found in the inhibitory fibers, the action of which has long since been compared to the phenomenon of acoustics known as the interference of sound waves.

Comparative anatomy in the study of the *gymnotus electricus* also furnishes us with an argument in favor of the vibratory theory of neurility, for, if an excessive amount of nerve force which this fish is capable of storing up and discharging is electric in all its effects, it seems natural to suppose that the normal amount also, generated in small quantities only, if not identical with the electric current, is so nearly so that a radical difference in their essential natures is impossible.

In the effect of the different currents upon the cells of the cerebral cortex, or the appreciation of sensations by consciousness, we have reached the great barrier that bars investigation, the relations of the material with the immaterial—a consideration that may well be left for solution to the race of men of larger minds and keener philosophy, who will be the result of mental development.

MUSCULAR ANOMALIES.

By HENRY DICKSON BRUNS, M. D.,
Professor on Diseases of the Eye, New Orleans Polyclinic; Surgeon in Charge of Eye Department, Eye, Ear, Nose and Throat Hospital, New Orleans,

The work by Hansell and Reber on muscular anomalies of the eye* is unique. So far as we know there is no better monograph on the subject, for it is more terse, didactic and systematic than the works of Stevens (*Functional Nervous Diseases*) and Ranney (*Eye Strain in Health and Disease*). The latter works are valuable mainly to the advanced practitioner; Hansell and Reber's book will prove invaluable to the student. Indeed, we know of no other work on the subject we can put into his hand, and it thus, in very fact, supplies a long felt want. In the first place, it is brief, the little volume consisting of 164 pages only; in the second place, it is comprehensive, comprising clear, short chapters on the anatomy and physiology of the eye muscles, ocular palsies, the heterophorias and the operations of tenotomy and advancement. It is very difficult to review such a work. There is little doubt that the muscular anomalies of the eye form the field least known and most to be cultivated in all the well-worked domain of ophthalmology. One hesitates to criticise well-digested, conservative statements and opinions based evidently upon a consideration of carefully recorded cases, unless one is prepared to call to his support an equally long record, and this few of us to-day can do. As a matter of fact, our views, for the most part, still remain in the somewhat shadowy realm of impression and belief. Thanks to the earlier labors of Stevens and Ranney, they seem to be now about to pass into the exact and definite, whither the infinite pains of a long line of predecessors have carried a large part of the oculist's knowledge.

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*A practical Hand-Book on Muscular Anomalies of the Eye. By Howard E. Hansell and Wendell Reber; P. Blakiston's Son & Co., Philadelphia, 1899.

For this very reason no other portion of ophthalmology offers such reward to the student, and we have labored in it, molding with what straw of opinion we could bring the crude material into brick, which, nevertheless, we are still forced to look askance upon as partly baked and hardly fit for permanent building. It is, therefore, as suggestion, query, in the attitude of a student desiring the elucidation of a matter, and in no magisterial vein that we offer the following comments:

In ocular palsies our experience has been overwhelming in favor of syphilis as the etiologic favor. Basing ourselves upon this alone, we could not but widely disagree with Alexander (p. 46) and his estimate of 59.4 per cent. Indeed, we can hardly drive ourselves to believe that injuries, rheumatism, gout, tuberculosis, tumors, meningitis, or cerebral disease of non-specific character are to be set down as the causative agents in so many as 40 6 per cent. of these cases. This doubt is strengthened when we reflect upon the extreme difficulty, nay, impossibility often encountered in eliciting the history of a long-past syphilitic infection from many men and the frequent occurrence of innocent infection; difficulties enhanced a thousand fold when the patients are women. Again, this very question of sex still further increases our doubts of Alexander's estimate. Out of seventy-five cases of ocular palsy we have tabulated, forty-seven were men and only twenty-eight women and, considering all things, men must be regarded as more contaminated with syphilis than women. We believe that the optic as well as the other ocular nerves is more liable to disease resulting from syphilis than from any other cause, and an analysis of 148 cases of optic atrophy shows 110 men to only 38 women. It has twice occurred to us to know by chance of a specific history that we do not believe anyone would have been able to discover, once in a case of atrophy of the optic nerves and once in sudden mydriasis without paralysis of accommodation. The results of treatment, too, have invariably tended to confirm our belief in the specific origin of these cases. We fail to recall a case of *recent* paralysis of an extrinsic ocular muscle where the subject has had the good sense to submit to a full and thorough course of anti-syphilitic treatment that has not been relieved. To our minds every full and thorough anti-syphilitic treatment must include vigorous inunction of at least a drachm of mercurial ointment (preferably mixed with the extract of belladona) and the frequent use of the Turkish bath (p. 46). Our views on therapy having been lately expressed at length in the review of Ohleman's work in the July number of the JOURNAL, it is not necessary to repeat them. Finally, owing to the saturation of the negro as we see him today with syphilis, his immunity from gout and the extreme rarity with which he presents phorias or tropias, it seems that some light might be cast upon the etiology of ocular paralyses by considering their frequency in this race. Refractive errors are most uncommon in the black, more frequent in the mulatto, and muscular anomalies are so rare as to be regarded as clinical curiosities, Collock, of Charleston, having deemed a case worthy of an extended report. Out of 143 cases of squint recorded at our clinic only 11 are set down as "colored" (8 per cent. nearly). On the other hand, out of 68 cases of paresis of the ocular muscles, 24 were colored, more than 23 per cent. So, among 147 cases of optic atrophy, 63, or more than 42 per cent. were colored. These figures are especially instructive when we know that colored persons have formed for many years only about 25 per cent. of those attending our clinics. One point as to treatment: Prisms, as our authors note on page 48, may often prove a great comfort to the patient by overcoming to a great degree, at least, the extreme annoyance of diplopia. When the degree of divergence is at first too excessive to admit of their employment, a patch or screen of some kind must be used to exclude the affected eye, but whatever means be employed we must be mindful to remove it as our patient improves. The patch should be replaced by a prism at the first possible moment, and this again by the weakest prism affording fusion so soon as may be, and so on until the cure is effected, for by so doing we encourage the paretic muscle to take up and exercise its function, while to permit the use of the patch or a too strong prism is to favor a condition of weakness and lack of exercise.

Turning now to part three, Functional Anomalies, and to the chapter on Heterophoria, we especially recommend Section 1 to the careful consideration of all beginners. It is the extremely conservative attitude of our authors that meets our highest commendation. Reflections upon the cause of squint, of heterophoria will not fail to lead reasoning minds to a conservative attitude in applying remedies: for he will little incline to radical measures for the relief of disorders, the cause and pathology of which are not quite clear, unless he belong to the class that "rushes in where angels fear to tread." No one, we surmise, will to-day deny the great part played in the production of muscular imbalance by refractory error; no one who has repeatedly broken up concomitant squints in young hypermetropes by correcting lenses or seen time and time again malignant hetorophorias disappear under the use of atropin and spectacles. But cases that do not recover or even tend to recover under these measures, the fact that the vast majority of the ametropic do not squint or suffer from serious heterophoria, and above all the not absolutely rare cases of grave heterophoria and actual heterotropia in emmetropia, warn us that this, in spite of high authority (p. 54), is not an adequate cause. Nor will unbalanced nerve action or over-function serve us better; sure it is that in most cases we must consider well neuropathy and strain, and the increasing demands of civilized life play a most important part in the production of muscular anomalies as well as refractive errors, and the concomitant accommodative asthenopia. But it is equally sure that "neurasthenia" and "blinded eyesight poring over miserable books" do not explain all. Robust men who do not overuse their eyes for near work will suffer from intractable phorias and some of the sturdiest and least self-conscious little cherubs will now and again squint most outrageously. It seems to us, therefore, and this conclusion has been strengthened by experience and reflection, that we must seek in anatomic peculiarity the still inadequate adaptation of structure to a (comparatively) recently acquired function, the underlying cause of muscular imbalance. And to this belief we incline more readily because it brings into relation at another point pathology and the great law of descent with modification. It is important to remember when we labor to prove that the position of rest of the eye is one of divergence (p. 35), we are contemplating the animal man, only. The confined gold fish, rolling his great eyeballs flatly, situated on each side of his head, out of all hope of correlation, each working independently, is familiar enough; the bird, the domestic fowl, cocking his eye and turning his head first upon one and then upon the other side, is a common enough sight; our horse looks sideways at anything that alarms him and we well know the use of blinkers on his bridle: even so high a quadruped as the almost humanly intelligent elephant looks but slightly forward; the harmless, necessary cat, it is true, gazes coldly and supiciously upon you, and the dog looks yearningly up into your face with both eyes; but it is only when we reach the sad, shifty-eyed monkey and the steady eyes below the level forehead of man that we see true binocular fixation. The slighter and yet ill-developed macular region as we descend the animal scale emphasizes this fact. This newly acquired functional position of rest, then, how easy to disturb it; clearly the slight strain incident to a refractive error or to prolonged near work, the imperfect distribution of nerve force emanating from a fagged or over-wrought nervous system, or even lacking, or togethei with either or both of these, the slightest increase or decrease of leverage, due to the displacement by so much as a millimeter of the origin or insertion of a straight muscle, will be enough, and all observers agree that the insertions, which are the more readily measured, vary. If this theory be true we begin to perceive why certain measures producing relief in one case prove inadequate in another. The theory proves satisfactory in explaining the lack of success from all but the most radical measures in certain cases, but unfortunately brings us no nearer to foretelling what these shall be; we must as yet be content with the method of elimination. True, the eliminative method, the method of applying successively more and more radical means, until we are brought face to face with the question of operation, taxes the patience of both physician and client, and often strains the confidence of the latter to the breaking point; but if a man be honest we do not see how in the present state of our knowledge he can proceed otherwise. To those who do and have done more must be brought all the harm that has of late so abundantly accrued to the sufferers, to our profession as a whole, and to the science and art of our special department, by hasty and indiscriminate muscle-clipping. It is tempting to set to ourselves limits beyond which it is useless to attempt the correction of a certain phoria by the milder means, and to many the temptation is enhanced by the desire to hold a patient who otherwise may betake himself to some one who promises prompter relief by the operative road. Our chagrin is not lessened by the fact that now and again such cases prove to be of those exactly suited to operative treatment, and the muscle-clipper gains *kudos*, while we appear to the uninitiated lacking in knowledge. Nevertheless, if we be loyal we must abide by the command of our mistress, Art, and console ourselves with the thought that at the final accounting we will not be chargeable with having made the art which does good to all responsible for additions to the sum of human suffering. For we repeat, though it may be tempting to say to ourselves that such and such a degree of phoria may at once be set aside for operative treatment, few who have candidly addresed themselves to the lessons of a large experience have not met with cases apparently extreme and unpromising that have with time and patience yielded to gentler methods. Who among us to-day can certainly foretell the future of a divided muscle? Especially if it be one of those great muscles of civilized life, the internal recti? Knapp, with half a century of practice behind him, thinks that the effect of tenotomy of the internus increases for at least two years (Norris and Oliver's System). Nowhere, however, have we yet seen a study of the effects of age upon muscle balance. Perhaps the material for such a study is not at hand. What will be the effects of the tenotomy of an internus that relieves an esophoria in the youth of twenty to-day, when twenty-five years have passed and presbyopia and general muscular adynamia begins (see p. 9)? We know in general that failure of convergence goes hand in hand with failure of accommodation, but we do not know much more. Another consideration that must give us pause: while with our authors we do not doubt the production now and then of severe reflex neuroses (especially chorea) by refractive or muscular errors, it is, as we would expect, in the neurotic, the neurasthenic, and, most dangerous of all, the hysterious (to coin a word), that we frequently find high muscular anomalies. Such cases will tax all our powers of discrimination not only as specialists, but as acute physicians and experienced men of the world. It is true that certain of these cases often supply the most brilliant instances of the beauties and benefits of muscle clipping, particularly if the tenotomy has been dextrously "graded." On the other hand, they all too frequently furnish the most atrocious examples of over rash or positively dishonest surgery. Not seldom these individuals have heard of muscle cutting for the relief of the symptoms from which they suffer, and with the curiously confounded motives of the neuropath positively long for "an operation." But when we have tenotomized a muscle temporarily improperly (may we say hysterically) innervated; when we have divided, advanced and redivided, converting successively one phoria into another without relief to symptoms apparently almost maddening, "what art can soothe our melancholy, what tears can wash our guilt away" for the stupendous folly to which we have stooped? Here, then, the experienced practitioner finds need of all his resources and self control; how cautiously should the beginner tread the field. Herein lies, we say again, the never-to-be-too-highly commended virtue of this little volume. For it must not be gathered from what has preceded that either Doctors Hansell or Reber or ourselves decry or shrink from operation in suitable cases. But the demand for operation must be determined not only by patient examination with all the modern means of diagnosis until we are sure we possess all data bearing upon a correct understanding of the nature and degree of the defect, but, without regard to time, without daring to allow ourselves to be hurried, we should give all those milder methods of any promise a fair trial, and the reiteration of this precept calls for praise, not excuse (p. 106). The examination, then, of a patient who enters our office complaining of symptoms which suggest refractive error or muscular anomaly calls first for a thorough test of the refractive condition under atropin (we distrust all substitutes), and again after the effect of the mydriatic has worn off.

In cases at all complicated we use mydriatics up to and even past fifty years of age, experience having convinced us that many, especially the highly ametropic, retain a high degree of accommodation long after the conventional presbyopic age (pp. 93 and 123). Should a muscular anomaly be discovered, a further use of atropin is indicated; for not only does complete rest under the mydriatic often break up the headache and other pain due to asthenopia, a result frequently not obtained by the prescription of even very accurate glasses without the drug, but a high phoria will in many cases disappear or sink to a degree that the wearing of appropriate lenses may be left to relieve. These advantages, shall we say necessary data, are foregone by those who attempt to do refractive work, without a mydriatic, and we have even known double tenotomy of the internal recti to be seriously proposed to a patient whose distressing esophoria subsequently disappeared while he was wearing lenses, correcting the total H. HAs. Not only do we concur in the insistance of our authors upon the necessity for a fair trial of correcting glasses, but if the phoria show the slightest tendency to lessen while the patient is under the mydriatic, we insist upon its use for ten days, two weeks, or, if the lessening is progressive, so long a time as may be necessary to produce relief. There is no doubt that a very large number of esophorias may be made to disappear by this enforced rest alone—eye rest without a mydriatic being impossible. Correction with prisms will, we agree, be the next step if rest and spectacles fail, and we coincide fully that their usefulness will range from three degrees to ten degrees. Our experience is that nearly all emmetropes or hypermetropes, living under the conditions of modern civilization, have esophoria of two or three degrees, that in the vast majority of instances causes no symptoms and calls for no correction. And here we may digress a moment to say that, in our opinion, the folly of prescribing glasses, save for the purpose of improving vision or relieving symptoms, is not stated with sufficient force in our texts. What sillier than to insist upon the young out-of-door worker having moderate H. and free from disease or asthenopia, or a middle-aged myope, whose near work is comfortably performed at his far point, troubling himself with glasses? Usually, too, it is vain to try to make a heterotrope or phoric, who has attained thirty or over and been used all his life to monocular vision, wear glasses and use binocular vision, and it should be only tried, as a rule, when we are confronted with serious symptoms surely due to this cause. Again the prism of five degrees or over before each eye will only be tolerated by exceptional individuals. A strength of from three to four degrees on each eye we have found the common limit in practice (p. 95). We take a more hopeful view of the treatment by prisms than our authors, it seems. We have found many cases where not only did the defect not increase but actually decrease and disappear under the use of prisms of low degree, especially when this was combined with the next step in treatment, prism exercise. It is almost needless to say that we entirely agree that prism for constant wear should be decidedly less than the whole degree of error. We do not agree, however, that "the very principle of action forbids a cure." In some cases the wearing of a weak prism acts as a constant prism exercise and the muscles trained to overcome the difference between the prism worn and the total phoria grew stronger, the prisms may be weakened and finally abandoned. In certain of these cases the symptons are relieved though the phoria persists. This we have observed quite frequently. Again, in certain rare cases of esophoria, which we are bound to regard as irritative, the relation between accommodation and convergence in a hypermetrope having become disordered, convergence being too strongly performed, especially in near work, we have found all symptoms permanently relieved by the use of moderate prisms, bases in, for reading and writing. That "a constant relation does not exist between the convergence for distance and for the near point in cases where equilibrium has been lost" (p. 95), coupled with insistence that glasses are to be prescribed (save in rare cases) only for relief of symptoms, are dicta that can not be too often or forcibly reiterated to the student. In the third place, in all cases well regulated prism exercise (p. 93) should be conjoined to the use of mydriatics and correcting glasses and prisms. Our experience leads us to believe this to be the most useful and not sufficiently used method of relief and cure, especially in recent moderate cases of exophoria—insufficiency of the internal recti. Unfortunately it calls for perfect confidence between the patient and physician; so that the former will persist for a long time in its use although we can give no positive promise of cure. The practitioners of our branch are oftimes too hurried to perfect such relations. Here, too, it is to be remembered that the symptoms, discomfort, pains and aches, may be relieved, although physical evidence of phoria may persist. Finally, if after patient trial all these means have proved abortive, there remains nothing but a resort to surgery and nowhere have we seen the indication for these operations and a description of their steps more clearly and tersely given than in the work under consideration (pp. 96, 110, 127, 140, 144, 153, 163, et seq).

After this expression it only remains to point out a few instances wherein we disagree with our authors, in the sincere hope that from frank statement and consideration of all conflicting opinions there will ultimately be evolved the unanimity of certainty. In the first place, while we agree that the Maddox rod is a more exact and truthful test than the prism test, we have not found it to show exophoria to be more frequent than esophoria (p. 63); for, as we have said, nearly all emmetropes and hypermetropes, who live under civilized conditions, show esophoria. In the same patient the Maddox rod will undoubtedly show a greater degree of esophoria than the prism test, and if all cases are fully and carefully tested, more will be found who complain of symptoms resulting from exophoria than from esophoria; this, of course, is to be expected. We are completely in accord with the views that esophoria is an active condition, and that tenotomy is the correct operation for its relief; exophoria and exotropia are usually passive and are to be met by advancement (p. 111), but we are entirely at variance with the view that both eyes should be operated on at the same sitting. It is almost needless to say that in esotropia the tenotomy should never be excessive, never surpass the indications that have been so well laid down by Knapp in his article in Norris and Oliver's System. In exotropia we would by no means be be thought to argue in favor of a violent and restrictive advancement. But this being clearly understood, we are strongly in favor of operating upon but one eye at a time. Our prime reason is that in all but the most excessive phorias this will often be found all sufficient; for even a large number of tropias are completely relieved by moderate operation on one muscle, and the element of time is all important, for in scarcely any place can we judge correctly of the permanent from the immediate result. This is less true, we admit, and less important in dealing with the outward tendencies and turnings than the inward. For but little harm is done by even a decided inturning of the eyes, and all observers agree that the effects of advancement rapidly diminish. What harm can be done by waiting to see if our single advancement, aided now by correcting glasses and prism exercise, shall prove sufficient? We can at any time take up the other muscle, and even combine a tenotomy of an externus if necessary. While this may not seem as brilliant as complete correction by binocular operation at one sitting, it will insure us against that most mortifying of misfortunes, the having to go back over our own work and correct our own over-corrections. But if little harm is done by the creation of a slight artificial esophoria, the slightest over-correction, the production of the slightest internal insufficiency, is a calamity calling for instant correction by a secondary operation. For not only is it intolerable, but we know that it is almost sure to increase for a long period of time. As we have before mentioned, Knapp, after his great experience, thinks that the effect of tenotomy increases for at least two years. How careful, then, should we be to avoid anything resembling an over-correction. With all due deference, we see nothing in the argument on page 99 that weighs against these two all-important considerations: 1. That in many cases we spare the patient a duplication of the operative procedure. 2. That only by allowing ample lapse of time can we decide positively that a double operation is necessary. The only arguments our authors oppose are: That double operation is safe; that the pain and discomfort are not great, and that patients prefer to get the whole matter done with at once! To these we may reply that chances which may render the single operation unsafe (sepsis) are allowed to act upon both eyes in the double operation; that the pain, discomfort and duration of the operation can not be less than doubled, and that in our experience after one operation the patient has not been willing only, but anxious, to postpone the second, should it prove necessary, to another occasion. This anxiety would be changed to positive insistence, we are sure, did the patient thoroughly understand that the double operation increased the *chance* of over-correction and subsequent secondary operation; and we do not see how this can be denied in tenotomy of the interni. Our argument is strengthened by agreement in the author's opinion expressed on this same page: "We can not admit that the tendency of the visual lines inward is a monocular affection"; for this very reason the effect of any alteration in the length of any straight muscle is immediately apportioned between the two eyes. Moreover, the plan of operating upon one eye alone and then allowing ample time to perceive the full result before attacking the other, seems to us in accord with the general plan of proceeding slowly from the most conservative to the most radical measures, laid down by the writers as the only proper mode in the present state of our knowledge, a doctrine we have highly commended, as one of the great merits of their work.

On page 107 we must demur to the preference expressed for tincture nux vom. over strychnia. In our hands this preparation has proved one of the most uncertain and unreliable in the pharmacopeia, while with the alkaloids we know that a given dose will always produce a definite result. Usually, we believe, it is given in too small quantities to produce the benefits of which it is capable.

Probably we take a more cheerful view of amblyopia than Drs. Hansell and Reber; the amblyopia of squint, and we accept the limitation of the term to eyes that have vision lower than 20-50. Here again we are inclined to believe in an anatomic cause of the squint "acting in conjunction with a degree of H. high enough to disrupt the association of convergence." We believe that when this disturbance begins at a critical period of life, just when the eyes commence to be accurately used, the more hyperopic eye of the one having the rectus originating or inserted just a millimeter too near or too far out of the way, will be turned in, the eccentric image suppressed and binocular vision sacrificed to more acute and less laborious vision with the other eye; and this can not be properly called congenital. Children squint at two periods of life: first, as infants when observation and the evolution of binocular vision in the individual is just beginning, and this is always recovered from. This would not be the case if the amblyopia or the squint were truly congenital; secondly, at two or three years old when the accurate use of the eye during a large part of the day for objects much nearer than twenty feet is begun. This takes place only under civilized conditions and savages and black negroes do not quint. Never have I heard a mother declare that the squint has existed from the birth of her child. Always it is asserted that the squint dates from some striking event (a fall, a convulsion) occurring in the second or third year. Now we conceive that in an infant born (usually) hypermetropic one or another rectus so originates or is inserted that the moment of the muscular leverage is not identical in each eye, and when the child, with its powerful accommodation, begins to use its eyes for that close and exact scrutiny of all objects, which we see in small children, seizing everything movable in its hand and bringing it to the nose, or moving its nose close to all immovable objects, the eye upon which the greatest leverage, no matter how slight, is exerted, is turned too far in; the comparatively slight advantage of binocular vision at this close range is sacrificed to the superior advantages of a more readily maintained accommodation and a large, clear (monocular) image. These are the habits of vision we note in all small children, and this is the time that the child is said by particularly observant parents to be "getting a trick of looking cross-eyed;" but the habit soon passes away, or sometimes is broken up by constant reproof in those in whom no anatomic basis for the defect exists. But where it does exist, the squint persists, becomes concomitant, and then more and more fixed, and by the time the child is old and intelligent enough to know its letters and permit of careful examination of the eyes, we find the image suppressed and amblyopia developed.

In our experience such eyes in young children in the early stages of amblyopia closely resemble eyes without a yellow spot, there seems to be no temptation to exact and particular fixation; this is the condition we should expect according to the theory of evolution in an eye that is undergoing functional retrogressive metamorphosis. We believe, therefore, that the amblyopia is acquired, not congenital. The argument that an eye sees well after the extraction of a senile cataract, though blind for many years, avails nothing, because the faculty of exact fixation, both bin- and monocular, have been long acquired and perfected before the misfortune befell. We believe it will not be denied, however, that children from whom a (virtually) congenital cataract is removed usually exhibit a notable degree of amblyopia. We are obliged to fall back upon this anatomic disagreement, no matter how slight, because no other hypothesis seems adequate to explain all the facts, for:

1. All hypermetropes do not squint, not even all very high hypermetropes; nor do all hypermetropes who have high amblyopia in one eye. We know it has been asserted that squint is more common in moderate H. than in very high H., but then moderate H. is vastly more common than high H. It remains to be shown that squint is proportionately more uncommon in high H.

2. In H. it is always the more faulty eye that squints; the flatter the eye the greater the leverage of the rectus; the more ill-developed the organ the greater the probability of multiple anatomic anomalies.

3. Though we meet with esophoria in young myopes, this generally passes into exophoria, and even exotropia as they grow older. The condition does not favor turning in one eye and sacrificing binocular to large, clear vision with one eye. The globe elongates under the strain and obviates it. Our observations have included monocular amblyopia in young myopes without squint, and we have often observed this condition in those past middle age; here the myopic organic changes forbid our ascribing with certainty the failure of vision to amblyopia.

4. We have seen severe esotropia in those with good vision (20-30) in each eye. The squint is not monocular, but truly concomitant; one eye, however, being nearly always used to fix. The eye usually turned in must be that in which anatomic peculiarity gives the rectus the greatest muscular leverage.

5. We have seen severe esophorias, and even esotropias, in emmetropes, with perfect vision in each eye. We can only ascribe the defect to some asymmetric origin or insertion of the muscles.

6. Those with monocular senile cataract never acquire squint even when the vision is 1. p. one eye and 20-20 in the other. We can not remember to have seen a case in which squint developed late in life as the result of loss of vision in one eye. Accommodation is gone and the conditions leading to the acquirement of esotropia are wanting; long education maintains binocular fixation and prevents amblyopia.

7. Those who lose vision in one eye in youth usually squint. There may be esotropia or exotropia. What but anatomic peculiarity determines this? Refractive defects, if marked, amount to the same thing; if the accommodation be active H. favors the leverage of the interni, M. of the externi. Here a very slight moment will determine the turning, as there is not the slightest binocular vision to hold it in check.

8. We have seen high amblyopia in one eye without any tropias. If amblyopia is the cause of squint these cases are inexplicable. Here, although the amblyopia is high, 20-200,

there is vision enough to maintain the tendency to binocular fixation and, we suppose, perfect anatomic symmetry.

9. If heterophoria and tropias depend merely upon "some disturbance of innervation" it seems reasonable to suppose they could be relieved by the milder measures of paralysis of accommodation, forced rest, correction of refractive errors, the use of prisms and prism exercise, together with appropriate treatment and hygiene. And this we believe to be the case in the great majority of instances. But in established phorias and inveterate tropias, with an anatomic basis, only surgical rectification of the symmetric muscle–leverage can produce permanent results. Unfortunately we can not distinguish these cases *a priori* with any certainty.

No. 10. In all operative phorias and in most tropias, even where the amblyopia remains unchanged, we attain permanent results by a skilful operation; when the squint is due to loss of vision operation rarely gives accurate and permanent relief. If the amblyopia were the efficient cause of the squint where it is not greatly diminished by treatment or operation it should lead to recurrence. We conceive that where the operation has secured almost perfect equality of muscle–leverage between the two eyes the amblyopia, even though high, affords sufficient vision to maintain the tendency to binocular fixation. As we have said, not all highly amblyopic eyes develop squint. Where vision is entirely lost in one eye the slightest inequality in muscle–leverage, even that due to the refractive build, will determine squint, and our operations are almost never sufficiently exact to obtain perfect balance between the two eyes. In fine, the exactness of an anatomic symmetry and muscle-leverage is the efficient cause, the diminished vision being the exciting cause only.

Finally this view is strengthened, because our experience leads us to believe the amblyopia of both squinting and non-squinting eyes is in most cases improvable. Amblyopia, monocular or binocular, is often improved by exact correction or refraction. It has been greatly improved in the squinting eye without operation. After successful squint operation the vision in the amblyopic eye very often improves, and we believe if attention be paid to the maintenance of stereoscopic vision it will often continue to improve. The importance of this has only comparatively recently been pointed out, and we have every reason to think is almost totally neglected by most ophthalmic surgeons. Even long continued observations on the phoria, left after operation, is now-a-days the practice of only a small minority of the most careful surgeons, and such a record is entirely lacking. Our own records do not allow us to concur in the dictum "amblyopia is incurable" except by the "destruction of the eye that had hitherto been used for vision" (p. 135). The exception seems to us to give away the contention. The cure, however, is difficult, and the records of such cure is limited, because it is very seldom attempted, operation being at once resorted to; secondly, it is seldom the parents of the child can be induced to attempt, and still less often to continue, the painstaking, laborious drill necessary to improve the amblyopia. But if we could more often control the parents of these children we are convinced improvement would be more frequent. We would not be misunderstood to imply that the treatment of squint should be undertaken without operation; on the contrary, we assert that immediately after the fitting of the best correcting glasses the operation should constitute the next step, for it will almost invariably produce some improvement in the amblyopia. We hold to the opinion, however, if after operation further efforts toward training the amblyoptic eye and the practice of stereoscopic vision were persisted in, still greater reduction of the amblyopia would usually be obtained. Holding this view, based upon our experience, we can not agree that amblyopia is, as a rule, congenital and, therefore, the efficient cause of squint. For we can not conceive of a truly congenital amblyopia not founded upon a congenital anatomic (microscopic) defect, and such an amblyopia will always be totally uninfluenced by training, the loss of the seeing eye or anything else. Such amblyopias are undoubtedly met with, but we believe them to be the exception, not the rule.

In closing this almost unbroken commendation of a text that we believe will prove not only suggestive to experienced workers, but of almost inexpressible value to the beginner and student, we desire to pay tribute to the genius of Dr. Wm. Thomson, of Philadelphia, the common master of Dr. Hansell and ourselves. One of the early workers in refractive problems, he most forcefully and constantly impressed upon all the necessity of patiently, exactly, accurately, clearing up and correcting any refractive error as a preliminary to the thorough understanding and treatment of almost all disorders of the eye. The result of that teaching, we believe, we can perceive on almost every page of this little volume. An example of that true genius which constantly builds better than it knows is seen upon page 106, where our authors explain the relation between myopia and exophoria and dwell upon the non-use of the accommodation in the former as being largely instrumental in producing the latter. The arming of the young myope with his correcting glasses to be worn for near work, as well as distance, causes him to cultivate the accommodation and so to lessen the danger of exophoria. Two decades ago Dr. Thomson was among the first to preach, to practice, and to insist upon the wisdom of correcting the defect in both H. and M., not only as exactly, but as fully as possible, and of then insisting that the patient wear his glasses both for far and near, especially in the case of young myopes. He based himself firmly upon the incontrovertible proposition that if E. is the normal condition it is our duty to turn the ametropia, at all ranges of the accommodation, into E., and that it could not fail to be of benefit in the long run, for while we know of many maladies that ametropia is subject to from which E. is exempt, so doubtless there are many of which we are still ignorant that should be lessened or avoided by restoring to the norm the abnormal organ.

Clinical Report.

CHRONIC ASTHENIC GASTRITIS WITH COMPLICATIONS AND WITH SYMPTOMS OF ABCESS OF LIVER.

By D. BORNIO, M. D., New Orleans.

Knowledge and common sense are essential to the successful treatment of any disease, but experience is as necessary as skill, which is an absolute requirement to all surgeons and doctors. For nearly two years I have been often called to attend Mrs. J. H., with the following history: Aged 44 years, constitution, robust;

temperament sanguine, nervous. From time to time she would have pain in the epigastric region; severe nausea, matter ejected with odor of vinegar (acetic acid), indicating great fermentation, bowels costive, temperature ranging from 102 to $102\frac{4}{5}$ deg., pulse 108 to 130, regular but so weak as to disappear on the slightest pressure. My treatment consisted in giving to my patient a light diet and calomel and soda, followed by administering pepsin, hydrochloric acid diluted, taka-diastase, papoid, lactopeptin and similar remedies indicated in such cases. Under these treatments she never improved; but in four or six weeks would again have a recurrence of the symptoms, more or less severe. Last 13th of May I was summoned to see her, and found my patient with symptoms again indicating chronic asthenic gastritis, as previously stated, besides a severe pain over the region of the ileo-cecal valve; bowels had hardly moved; temperature $102\frac{3}{5}$ deg.; pulse 135. The following day, pain was very severe over the appendix; fever, 103 deg.; pulse, 140; respiration, 29. I placed my patient upon four drop doses of fluid extract of nux vomica twice daily and a teaspoonful of olive oil every two hours, also ordered an ointment of ichthyol and belladonna camphorated to be applied over the seat of pain (there was a very noticeable induration felt in the region of the appendix).

On the 15th the patient was very restless. An hour before Dr. J. M. Elliot and myself met in consultation, the bowels moved freely. Dr. Elliot corroborated diagnosis of appendicitis with chronic asthenic gastritis, and recomended the continuation of the same treatment, adding enemas of water and glycerin. Mrs. H. gradually improved from that day on, and on May 30 I discharged her apparently well; temperature, $98\frac{4}{5}$; pulse, 83; appetite good, but on liquid diet.

On Agust 17, I was hurriedly called to see her, with symptoms as follows: Much gastric discomfort and great weight over epigastric region, nausea and vomiting; *had chills;* constipation; fever $101\frac{4}{5}$ deg. After ordering kola digestive tablets and cocain I retired.

On the morning of August 18, nausea entirely disappeared; bowels had acted once; temperature, 102; severe pain in the hepatic region; this organ was found enlarged and indurated.

August 19, 20, 21, 22 and 23, fever rose daily $\frac{1}{5}$ of a degree; chills occasionally; pain becoming very alarming over the hepatic region; eyes slightly jaundiced, fever rose to $103\frac{2}{5}$ deg., and there was still induration of liver very pronounced on left lobe, indicating the probability of an abcess. On August 24, I called in consultation Dr. F. W. Parham, who, after a very close and careful examination of the patient and the history of the case, suggested the use of the aspirating needle, which was done; three explorations with negative results. We then agreed to wait further developments, but meanwhile to put her under a course of melachol, tablespoonful every four hours, till a good evacuation was obtained, and the continuation of the kola digestive tablets after partaking of food. She began to improve daily, pain and fever disappearing gradually, and on the 29th seemed well—temperature normal.

OBSERVATIONS.

She having symptoms of gall-stones, passages were examined frequently for them—negative results.

I have had in my practice many cases of gastritis in its different forms, such as chronic hypersthenic gastritis, adenasthenia gastrica and three cases of gastritis glandularis atrophicans, but none to harass me as much as this case with its many complications.

Chronic asthenic gastritis can be confounded with adenasthenia gastrica and carcinoma, but other symptoms to confirm these last two being lacking, there being at no time any palpable tumor or hematemesis and in adenasthenia gastrica there is at no time any nausea or vomiting, my conclusions were that the case was chronic asthenic gastritis.

Prophylaxis. The diet, as Trousseau wrote and well said, viz.: "that the only suitable and propitious diet adequate to diseases was the one which *experience taught best* agreed with them."

The washing out of the stomach has given me excellent results, but my patients seldom submit to it. The cleaning of the teeth should be attended to after each meal. Alcohol is particularly injurious; chocolate and coca could be given in preference to coffee or tea in exceptional cases, as it is better borne; should there be intestinal trouble associated with chronic gastritis in any of its forms, we should still be more cautious till intestinal disorder has been brought under control. The following diet has given me best results: Barley soup, boiled rice, lean meats, fresh trout, soft part of oyster, yolk of eggs, young chicken, sweet apples and venison steak.

In bringing before the medical profession the above case, it is for the purpose of showing that an expectant treatment is always wise in cases where the symptoms do not point conclusively to a positive diagnosis.

Society Proceedings.

THE INTERNATIONAL CONFERENCE FOR THE PREVENTION OF SYPHILIS AND VENEREAL DISEASES.

"This meeting may be regarded as one of the most significant in which medical men have ever taken part, since it marks the first international official recognition of the dangers of venereal diseases to society at large. Not only was practically every civilized country represented, but the leading parts in the Congress were assigned only to those legal experts and medical specialists whose places at the very head of their respective professions are undisputed." So writes Dr. C. W. McMurtry in introducing a most excellent report of the meeting in the *Medical News* of September 30. The main discussions were grouped around the questions "The dangers of syphilis to society," and "The dangers of gonorrhea to society," in which Professors Fournier, Neisser, Kaposi, Lesser, Finger, Besnier, Lassar and Yadassohn engaged. Among others taking prominent part in the several discussions were Drs. Alfred Cooper, Jonathan Hutchinson and Drysdale, of London; Dr. Nevins, of Liverpool, and Dr. Liston Montgomery, of Chicago. The entertainment provided consisted in banquets and receptions, the most notable of these being the receptions by the King of Belgium and the Mayor of Brussels, and the ball of the Minister of Foreign Affairs, M. Favereau.

The organization of the meeting was excellent, for which the entire credit was due and was accorded to Dr. Dubois-Havenith, the secretary-general of the meeting. Before the session was concluded the members of the Conference presented him with a beautiful bronze statue as a tribute to his courtesy and attention.

The Conference began September 4 and was concluded September 8, when a series of resolutions were adopted unanimously, expressing the results of the several days' discussions; at the end of which a rousing vote of thanks was tendered the Belgian government and to the organizer, Dr. Havenith.

The resolutions follow:

1. That the International Conference for the Prophylaxis of Syphilis and Venereal Diseases expresses the desire that the various governments use all powers with a view to suppressing absolutely prostitution amongst girls who are regarded according to civil law as minors.

2. That the present Conference serve as a beginning for the foundation of an International Society for Moral and Sanitary Prophylaxis Against the Evils of Prostitution and Venereal Diseases. That such society shall publish a quarterly report or magazine containing articles by the members upon these social questions. That the next reunion of the Conference will be held in 1907 at Brussels, and every three years thereafter. That the official seat of the permanent committee shall be at Brussels. That French shall be the official language; but articles in French, German, English and Italian may be accepted for publication. The following provisional committee on organization was elected: President, M. Lejeune, Minister of State, Brussels; Vice President, M. Beco, Minister of Public Health and Hygiene; Secretary General, M. Dubois-Haveinth, *agrégé de l'Université de Bruxelles.*

3. Resolutions presented by Professors Fournier, Neisser, Hutchinson, Lesser, Wolff and Mracek. The Conference holds that a thorough knowledge of venereal diseases constitutes one of the most important means of combating the spread of these maladies. Governments are therefore urged to compel the most thorough education of students in this branch. That the instruction should, in all cases, be given by competent specialists, and there should be instituted in each university complete and obligatory courses upon these diseases. That each government should insist upon a strict examination in these subjects, to be presided over by specialists as requirement for the medical degree.

4. That the guardians of orphans be held responsible to the State for the moral welfare as well as the material interests of their charges. That those entrusted with the education of youths will give all possible solicitude to their moral development, which is to include the common-sense principles of temperance, and the cultivation of a high, manly respect for woman, whatever be her social condition.

5. The Conference pleads that governments use the greatest possible severity in punishing panderers and procurers.

6. Proposed by Professor Saundby, on behalf of the British Medical Association: The Conference demands of the governments of all countries the establishment of a commission, whose duty it shall be: (1) To determine the frequency of venereal diseases amongst the civil population exclusive of temporary variations. (2) To inquire into the institutions already in existence for the treatment of venereal disease, the distribution of such hospitals, the number of beds at the disposal of each locality, and the proposal of the most effective measures for the treatment of these maladies. (3) The collection of different opinions concerning the best means for preventing and effacing the dissemination of venereal diseases among the civil population, and reporting their conclusions.

7. Proposed by Professor Lassar, of Berlin: The governments are urged upon all favorable occasions to call the attention of the population, and particularly the young men, to the dangers of prostitution to both sexes and the sinister consequences of venereal diseases.

8. Proposed by Drs. Pierson and Fiaux: The Conference recommends that a uniform system shall be used in all countries for the gathering of statistics concerning prostitution and venereal diseases.

Communication.

THE STATE BOARD OF MEDICAL EXAMINERS HEARD FROM.

NEW ORLEANS, *September 25, 1899.*

To The Editors New Orleans Medical and Surgical Journal: In the August number of your Journal I noticed an article attacking the Board of Medical Examiners for non-action against parties practicing medicine in Louisiana without having complied with the law, and another article in this month's issue bearing upon the same subject.

It is certainly strange how very few M. D's. seem to underderstand the duties of the board. They lose sight of the fact, that the members of the board are not supposed, under the law, to make it their special duty to hunt up violations by tracing from one parish to another—give up their profession, and defray their own expenses. If such a course be expected of the board, it does not come within the limits of what the board understands to be the extent of its obligation, under the existing law, to the medical profession.

Numerous complaints are hurled at the board from every nook and corner of the State to suppress violations of the medical law, and few, if any, are willing to give aid and assistance to remove those who are just cause of complaint under the law. The board is not supposed to know who are officially registered or not, and unless the moral and material assistance is given by all legal practitioners in having the law rigidly executed, it will naturally follow as a result that intruders so much complained about will continue illegally practicing unmolested. A very common mistake is being made that the board is all powerful, and by the mere fact of its existence should at once exterminate the whole class of impostors, but unfortunately, every case must necessarily travel the same slow course through the courts, and every new proceeding for contempt must be accompanied by new evidence, which is often almost impossible to obtain.

The secretary of the board reported to the Orleans Parish Medical Society some time ago the cause of the delay in the proceedings in the ''Abbo,'' or Prosser, case.

The following letter from Mr. Ernest T. Florance, the attorney of the board, bears on the same subject:

Dr. H. S. Cocram, President State Board Medical Examiners:

Dear Doctor—In regard to the Prosser case, permit me to explain: As you are aware, after the injunction issued from the Civil District Court of this parish, the suit against Prosser was transferred to the United States Court on the ground that Prosser was not a citizen of the State of Louisiana.

The papers having been deposited in the United States Court, the judge of that court ordered the injunction issued by the Civil District Court to stand as an injunction of the United States Court. Shortly thereafter, and before we could procure the evidence showing that Prosser had violated the injunction, the U. S. Judge left for his summer vacation. In consequence of this it became impossible to try Prosser for contempt of court, as there was no judge who could preside over the trial in this city. It was hardly to be expected that Judge Parlange would come back from his summer trip merely to try this one proceedings, however improper the conduct of Prosser was. At all events, neither the Board of Examiners nor its counsel could compel Judge Parlange to return, and there was, therefore, no means of stopping Prosser from continuing to practice. There is a mistaken idea as to the meaning of the expression ''that a party can not do an act which he is enjoined from doing.'' The meaning of the words "can not" is merely that he will be punished for so "acting." The phrase does not mean that he can be physically prevented from violating the writ. It is an incorrect expression of the same nature as one frequently used, in regard to the sick, that they can not eat some particular kind of food, meaning, of course, that they can physically eat it, but that the eating is likely to result in death.

Law is very rarely directly preventive; it is punitive, and preventive chiefly by means of threatened punishments. I hope you understand that there is no power to prevent Prosser from violating the injunction. The utmost that can be done is to punish him for violating it. I have no doubt that as soon as Judge Parlange returns he will maintain the dignity of his writ, of which Prosser is in daily contempt.

Trusting I have made myself clear,

Believe me yours faithfully,

ERNEST T. FLORANCE.

I hope the medical profession will now understand and realize that the apparent delay in the proceeding of the several cases before the courts is not due to any non-action or lack of interest on the part of the board, and while on the surface it may appear to some to assume the role of a sleeping beauty, yet the board is doing its utmost to rigidly enforce the law, to punish all violators and trying to elevate the standard of medical education in Louisiana.

Very truly,

H. S. COCRAM, M. D.

President State Board Medical Examiners.

N.O. Medical and Surgical Journal.

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

A UNIFORM MEDICAL PRACTICE LAW WITH RECIPROCAL FEATURES.

The Wayne County (Michigan) Medical Society has agitated the question of reciprocal legislative enactments in all the States having uniform regulations for the practice of medicine, by which physicians who have qualified in one State may practice in another upon submitting evidence of such qualification from the State granting the original license.

The idea is a good one and worthy of eventual fulfilment.

Meantime, the agitation must needs continue. Of fifty-one States and Territories addressed upon this question (submitted in careful detail), thirty-six States and three Territories replied, and their answers were, in the main, favorable to some uniformity in methods of licensing physicians upon a plan of reciprocity. The negative replies were based on various reasons, one of those given being the existence of a National Confederation of Medical Examining and Licensing Boards. The circular issued by the committee of the Wayne County Medical Society very properly remarks that final results can not be expected for some time yet.

In thus noticing the laudable and progressive movement of our Michigan confrères, the JOURNAL feels that all has been done that can be done just now. Only a fraction of the United States requires adequate examination before a license is granted. In many of those States where legislative enactment has been secured, preliminary qualification is not demanded or expected; in some States any medical degree is accepted, and in others, e. g., Mississippi and Texas, no diploma is required.

The voice of the medical profession has continually been raised in all quarters for the protection of its rights, but legislators are always slow in granting either their judgment or their votes where only justice and right are the arguments.

So we see a long road with many turnings before the reciprocity legislation will prevail, although it carries with it the liberal acknowledgment of the equality of all who are qualified to meet in the arena of science.

EDDYISM IN COURT.

A highly sensational suit for damages, in the sum of $150,000, has been brought against the high priestess of the Christian Science cult.

One Mrs. Woodbury, formerly a follower of the Eddy, repudiated the faith, and because of this and some of her public utterances she was subjected to some classic billingsgate and other libel at the hands of the Eddy.

In the *Boston Post*, of October, 4, a full recital of the grounds of suit is given in the kind of detail which will show Eddyism in no favorable light. A full exposé of the claims of the cult is related with explicit detailed account of the choice invectives used in the "Mother Church" by the high Priestess on the occasion of her Christian rebuke to said Mrs. Woodbury. The outcome will be interesting, and the trial must be. This looks like the beginning of the end.

THE STATE BOARD OF MEDICAL EXAMINERS AND THE LAW.

Anent the pleading of the State Board of Medical Examiners, which we publish on another page, we have excerpted the passages of the act regulating the practice of medicine which bear on the duties of that board:

SEC. 12. Be it further enacted, etc., That any itinerant vendor of any drug, nostrum, ointment or application of any kind, intended for the treatment of disease or injury, or who may, *by writing, print or other methods, profess to cure or treat disease or deformity by any drug, nostrum, manipulation, or other expedient*, in this State, shall, if found guilty, be fined in any sum not less than twenty-five (25) dollars, and not exceeding one hundred (100) dollars for each offence, to be recovered in an action of debt, before any court of competent jurisdiction, or shall be imprisoned for a term of not less than ten (10) days or more than thirty (30) days, or be both fined and imprisoned.

SEC. 13. Be it further enacted, etc., That *any person shall be regarded as practicing medicine*, in any of its departments, *within the meaning of this act, who shall append the letters M. D. or M. B. to his or her name, or repeatedly prescribe or direct, for the use of any person, or persons, any drug or medicine or other agency for the treatment, cure or relief of any bodily injury, infirmity or disease*. This act shall not apply to farmers and planters when exclusively practicing, without compensation, on their employees and tenants.

SEC. 14. Be it further enacted, etc. That *any person practicing medicine*, in any of its departments, in this State, *without first having obtained the certificate therein provided for, or contrary to provisions of this act, shall be deemed guilty of a misdemeanor*, and upon conviction thereof shall be punished by a fine of not less than fifty (50) dollars, or more than one hundred (100) dollars, or by imprisonment in the parish jail for a period of not less than ten (10) days or more than ninety (90) days, or by both fine and imprisonment for each offence. *It shall be the duty of the respective district attorneys to prosecute violations of the provisions of this Act, before any court of competent jurisdiction.* * *

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SEC. 18. Be it further enacted, etc., That THE SAID BOARDS SHALL REPORT TO THE PROSECUTING OFFICER OF THE STATE OF LOUISIANA ALL PERSONS VIOLATING THE PROVISIONS OF THIS ACT. * * * *

Having done this, we desire to call the attention of all practitioners in the State to the broad interpretation which the law may put upon the provisions of the act, in order that they may help the board by reporting all infringements, so that the board may exercise their office duly, and as they profess they wish to do and as the law provides they should do. We have all the law we need, but we want the enforcement, the board willing.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

A MILK-CYST OF THE LEFT MAMMA IN A BOY 13 YEARS OLD.—Mr. Kirmisson, in *Revue de Chirurgie* of August, 1899, relates the case of a well-developed boy, aged 13 years, who, after a blow on the left breast two months previously, noticed a tumor, the size of a mandarin orange, developing in that region.

The growth was round, movable and indolent.

Mr. Kirmisson suspected a serous or sero-sanguinolent cyst.

On aspirating he was surprised to find a fluid resembling normal milk. The histologic examination and chemic analysis revealed the presence of real milk. This is a most interesting and rare case.

COSTAL OSTEO-SARCOMA—EXTIRPATION—ACCIDENTAL OPENING OF THE PERICARDIUM IN A WOMAN WHO HAD THREE YEARS PREVIOUSLY UNDERGONE A RESECTION OF THE LEFT SUPERIOR MAXILLA FOR SARCOMA OF THAT BONE—RECOVERY.—Mr. Chavannaz, in the August, 1899, *Revue de Chirurgie*, narrates the case of a woman, aged 46 years, on whom he had operated November 20, 1895, for an embryonal sarcoma of the left superior maxilla. The patient remained without a recurrence until September, 1898, when a nodule appeared on the left sixth rib. The patient would not consent to its removal until January, 1899, when pains appeared and the tumor had grown.

Mr. Chavannaz detected at that time a spontaneous fracture. He resected the diseased rib, cutting far away from the tumor, and extensively removing neighboring muscular bands. On tilting the rib outward a whistling synchronous with the respiratory movements was heard. A slit in the pericardium was recognized and sutured.

For the next two days a go and come precordial bruit was audible, with its maximum at the apex; this bruit ceased entirely January 22, and the patient recovered.

Mr. Broca reported this case in July, 1899, to the *Société de Chirurgie*, laying stress on the long interval which elapsed before recurrence, with persistent freedom of the primary focus. The precordial bruit, which Mr. C. attributed to the friction of the cat-gut sutures, could be, in his opinion, ascribed to blood-clots.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller,
New Orleans, La.

In discussing the subject of pelvimetry as an aid in the physical diagnosis of obstetric cases, under the head of pelvic measurements, Dr. Edward A. Ayers states that the *external conjugate* is of great importance, and must be taken very carefully. It is not always necessary to place the patient on her side in taking this measurement, as there is sufficient curve in the lumbar region to allow the instrument to be placed against the sacro-lumbar point while the patient lies upon her back. The points of application of the pelvimeter for taking the external conjugate are the dimple which is felt just below the spine of the last lumbar vertebra posteriorly and the anterior surface of the symphysis anteriorly, at a quarter of an inch below its upper border. This measurement is of more value and significance than the others, and should always be taken with great care. A difference of an inch in the measurement may be obtained by a slight error in placing the measuring tips of the pelvimeter. If the posterior one be placed below the proper point the diameter obtained will be too short, and cause the examiner to fear the difficulties of a narrow conjugata vera. The posterior point can be most surely obtained with the patient lying upon her side, and with the muscles of the lumbar region quite at ease. The lumbar spines then define themselves more readily, and less doubt is felt as to when the last spine is found. We should endeavor to place the anterior tip of the instrument just within the superior commissure, and so get it nearest the pubic bone. The average diameter of the external conjugate is 7⅞ inches (20 *c. m*). Some writers make it 7½ inches. In attempting to forecast the character of a given labor we give considerable weight to the dimension of the external conjugate. We can not specify, but in a general way it may be said that we may expect a delivery in a woman of average weight, with fetus of seven pounds weight (estimated), where the external conjugate measures eight inches, and where no special abnormalties exist, without moulding of the fetal head. With an external conjugate of 7½ inches we may expect moulding, and of 7 inches sufficient obstruction to render assistance "probable."—*Obstetrics.*

In ascertaining the causes of maternal dystocia, Cutts (*Annals of Gynecology and Pediatry*) says that the condition of the pubis is always to be considered.

Normally the pubis is placed at about a right angle to the plane of the superior strait of the pelvis, but there may be a tilting of the upper part of the pubis toward the sacrum, causing the true conjugate to be diminished and a consequently narrowed inlet, or the same condition may occur of the inferior end of the pubis, causing a diminution of the diameter of the inferior strait. Other conditions of the pubis to be noted are its length and thickness.

The length of the pubis and sub-pubic ligament varies from one to three inches. With a long pubis the difficulty in delivery is encountered in the middle and lower part of the pelvic canal, and accompanied with the condition just mentioned, in which the lower part of the pubis is inclined toward the sacrum, may produce severe dystocia. The thick pubis is most frequently found in women of stout build and having the evidence of a heavy skeleton. In connection with the thick pubis a cartilaginous ridge over the symphysis as thick as a quarter of an inch is sometimes found and should not be overlooked in practicing pelvimetry.

At the Session of the International Congress of Gynecology and Obstetrics, at Amsterdam, Professor Leopold presented a paper on the indications for Cesarean section as compared with those for symphysiotomy, craniotomy and premature induction of labor. The conclusions offered were as follows:

1. *Before term.* When there has been one or more difficult labors caused by pelvic deformity, premature induction of labor is indicated when the pelvis is not too much contracted (conjugata vera more than 7 centimetres in flattened pelvis, more than 7½ centimetres in the justo minor pelvis). The best moment for intervention is the 35th week of pregnancy. Good results are not to be expected unless the membranes remain intact and there is a head presentation.

2. *At term.* Craniotomy is indicated (*a*) when the child is *dead* and labor does not advance, even when the pelvis is only slightly contracted; (*b*) when the child is *in danger*, the contracted pelvis being an obstacle for spontaneous birth, forceps and version being too dangerous or impossible.

This rule is valuable equally for hospital and home practice. The danger to the mother is too great to risk Cesarean section or symphysiotomy when it is not quite sure that a living child will be born.

When the child is in *perfect condition* craniotomy will be performed only as an exception in hospital practice; but in private practice it is indicated when spontaneous birth, forceps and version are excluded and the termination of labor is necessary, the obstetrician, all circumstances duly considered, regarding Cesarean section or symphysiotomy too dangerous. The conjugata vera must be more than six centimetres. In exceptional cases, when for private reasons it is important that the child be born living, should it be only for some minutes, the advice of a colleague is to be asked, and the family of the woman is to be acquainted with all the dangers accompanying the operations by which the child can be saved.

3. The Cesarean section has absolute or relative indications. In pelvis with a conjugata vera of 7½—6 centimetres, the indication is a relative one. When the diameter is less than 6 centimetres the indication is an absolute one.

Cesarean section on relative indications requires the fulfillment of the following conditions: A spontaneous birth being impossible, forceps and version inadmissible, the child in a perfect condition and the woman either in a hospital or in circumstances quite as favorable as to the operation itself and as to the subsequent treatment. When the circumstances are not favorable enough, craniotomy of the living child is to be preferred.

4. Symphysiotomy is only indicated in pelvis with a conjugata vera 7½ to 6½ centimetres; the indications are, therefore, much more limited than those of Cesarean section, and do not regard the pelvis of the second class (pelvis where conjugata vera is less than 7—7½ centimetres, but more than 6 centimetres). With this restriction symphysiotomy may compete with Cesarean section on relative indication, and requires the same conditions. When these conditions are not fulfilled craniotomy must be performed. The choice between symphysiotomy and Cesarean section, as relative indication, depends on the experience of the operator. The results of both operations, performed under the same conditions, are almost equal for the mother as well as for the child.—*Annals of Gynecology and Pediatry*, August, 1899.

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

CONVULSIONS IN CHILDREN.—Drs. J. A Coutts and A. M. Gossage considered that the frequency of convulsions in infancy is greatly exaggerated. This is partly due to non-discrimination between convulsions proper and the convulsive movements which are so common in infants shortly before death. Belief in the undue frequency of convulsions has been perpetuated by the use of unnecessary and misleading terms, such as inward convulsions, silent convulsions, secondary convulsions and the like. The causes are (1) predisposing, and (2) exciting; of these the first are the more important. The cause most commonly assigned is undue excitability or instability of the infantile nervous system, owing to non-development of the higher controlling centres. It is possible that too much stress has been laid on this instability of the infantile nervous system.

Other important predisposing causes are inherited neurotic conditions and the presence of rickets. The existence of craniotabes is probably of more importance as an evidence of an advanced degree of rickets than as giving rise to convulsions by allowing pressure on the brain through the softened bone.

Convulsions dating from birth are often due to hemorrhage, and are followed by spastic paralysis. Convulsions may occur at the onset of meningitis. Uremia is a well-recognized cause, but is very rare under the age of two years. Convulsions are often said to be frequent at the onset of diseases with a high temperature, but this has been over-estimated. In a series of cases of croupous pneumonia, which the reporters had collected, convulsions were not present at the onset in 5 per cent. of the cases. In another series of 300 cases, 42 occurred in children under 11 years of age, and in only 2 of these were convulsions present at the onset. Convulsions are often due to asphyxia rather than to pyrexia.

In the exanthemata, again convulsions are more frequent during the course than at the onset, and they may be due to many well-recognized causes. Thus, the idea that convulsions are equivalent to the rigor of the adult is contrary to the facts.

Peripheral irritation, such as teething, is usually considered of much importance, but increasing stress is being laid on the predisposing cause present. Severe injury, such as burns, may cause convulsions, apart from any predisposing cause.

Asphyxia convulsions are common, and the convulsions seen in dying infants may be due to this cause. Collapse of lung tissue is commonly found after death.—Reports of British Medical Association's Meeting, *Pediatrics*, October, 1899.

SUDDEN DEATH OF NURSLINGS.—Such occurrences often cause the condemnation of innocent persons, or, at least, shocking reflections on the attendants, physician, nurse, etc.

Usually, without warning, death comes like a lightning stroke while the babe is in its bed, or upon its feet, playing, etc. Autopsy reveals nothing, except a simple hypertrophy, more or less pronounced, of the thymus gland.

Sometimes there is a very short precursory period, consisting of dyspnea and asphyxia, but the hyphertrophy of the gland can not be made out during life, and at times the gland is not found to be exceptionally large on *post mortem.* Hence arise unjust and vile accusations of murder, as, for instance, the case cited by Berthelot, in *Archiv. für Kinderheilkunde;* reported also by Variot, in *Journal de Clinique Infantile.*

Strangely enough, though the thymus is subject to suppuration, tuberculosis, hemorrhage, carcinoma, sarcoma, etc., it causes sudden death only when enlarged by simple hyperplasia.

Sudden death of babies is also due to two other causes: Spasm of the glottis and abrupt extension of the head backward, the latter chiefly in rachitics with enlarged heads. The falling back of the head causes the trachea to be squeezed and closed by pressure between the vertebral column, the thymus and the sternum; death follows on the spot.

Speaking of sudden deaths of babies, it is well to mention also the circumstances under which their life is accidentally and unexpectedly ended, as, for instance (Howe, *Boston Med. and Surg. Journal*, January 5, 1899), by being suffocated while asleep on feather pillows or crushed under by one of the parents while in bed with them.—DR. BIENFAIT, *Gazette Médicale Belge*, September 21, 1899.

ELECTRIC TREATMENT OF PRURITIC DISEASES.—This is certainly the most effective of all the treatments used in such cases.

Dr. Legros in his recent thesis reports the results obtained in 750 cases by Dr. Bisserié, director of the Electrotherapic service of l' Hópital Broca, viz: 71 per cent. were cured; a remarkable showing as these cases were stubborn and of long standing. Static electricity, under all its different forms, was used, frictions, bath, douche, puff, effluvium, sparks, etc.

Dr. Legros has also tried D'Arsonval's currents with remarkable results, but their management is extremely difficult. In this, as in other methods of treatment, it is well to consider individual susceptibility or idiosyncrasy.

The diseases treated were chiefly of that class called by Brocq "*névrodermies*,"* general and local, viz: Hebra's prurigo, pruritus progenitalis (of scrotum, vulva, anus), etc.

The treatment was efficacious

1. In circumscribed pruritus and neurodermitis, 69 per cent;
2. In generalized forms, 66 per cent;

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*Dermatoneuroses.—ED.

3. In prurigo, nervous urticaria, etc., in which itching is all-important, the dermatosis ending when itching disappears, 86 per cent.

These figures demonstrate that if electricity be not absolutely effective in that class of diseases so remarkably persistent, it gives much more encouraging results than other remedial agents. How is the beneficial action of electricity upon pruritus accounted for? It seems to be the result of deep modifications impressed upon the general nutrition.—*Journal de Médecine et de Chirurgie Pratiques*, September 25, 1899.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Dangers of Acetylene.—The increased use of acetylene as an illuminant, with the possible dangers which accompany the use of this gas, will undoubtedly bring it into prominence sooner or later as a subject of medico-legal inquiry. E. Renouf, in the *Pharmaceutical Era* of July 22, 1899, in writing on the uses of acetylene says the statement is still current that it attacks copper and brass, forming an explosive compound. This is not true. Exhaustive experiments by Moissan and by Gerdes, keeping these and other metals in contact with acetylene for months at a time, have shown that the metals were not affected. The conditions under which the explosive copper acetylid is made in laboratories can not well occur in generators or gas-holders. It has been said that acetylene is very poisonous; the experiments of many observers, and especially those of Grehant, do not confirm this statement. Grehant experimented on dogs, causing them to breathe the mixtures of acetylene, air and oxygen, which always contained 20.8 per cent. of oxygen, this being the percentage of oxygen in pure air. By this device he was able to discriminate between the poisoning caused by acetylene, and suffocation caused by insufficient oxygen. A mixture of acetylene, 20 per cent. inhaled for thirty-five minutes, did not seem to trouble the animal. A sample of the dog's arterial blood contained 10 per cent. of acetylene. Grehant proved that acetylene simply dissolves in the blood plasma, while carbon monoxide forms a compound with the hemoglobin of the blood. A dog breathing a similar mixture of air, oxygen and illuminating gas, containing only 1 per cent. of carbon monoxide, quickly showed convulsive symptoms and died after ten minutes; its blood contained 24 per cent. carbon monoxide. Thus acetylene, while slightly poisonous, is less poisonous than coal gas, and vastly less than water gas, which contains a high percentage of carbon monoxide.

The writer speaks of the several explosions which have occurred in acetylene works. Most of these he attributes to gross carelessness. In two fires which have occurred, one in Paris and one in Berlin, in which acetylene works were destroyed, numerous cylinders were dug out of the ruins which had not been exploded.—*Medicine.*

TREATMENT OF TAPEWORM BY USE OF MORPHIN INJECTED INTO THE PROTRUDING PART OF THE PARASITE.—J. W. Kime, in *Medicine*, for September, 1899, says that "The attempt at removal of tapeworm by any of the tenicides is followed by a large number of failures which, by the method which I have used in two recent cases, might be converted into successes.

"It is a very common occurrence for the parasite under such circumstances to drop down into the lower part of the intestine and reattach itself with a surface of a considerable portion of its caudal extremity. I have sometimes been able, by copious injections of water or saline solutions, to bring away the head of the worm, but far more frequently have I succeeded only in breaking off the worm.

"Recently it occurred to me, while attempting to remove one of these pests, fifteen feet of which was visible and ten feet invisible, that I might take advantage of the latter portion by properly medicating the protruding part. I, therefore, after tying a string moderately tight around the worm about three inches below the patient, injected above the string, directly into the substance of the worm, one-half grain of morphin sulphate; the protruding part was then severed with scissors just below the ligature, and the three or four inches remaining was passed up through the sphincters and left there about ten minutes.

"A large injection of water was then given, and the upper portion of the worm was passed entirely motionless and apparently dead.

"Since reporting this case in the *Iowa Medical Journal*, I have treated one other case the same way and with the same results.

"Most varieties of tapeworm have a pair of longitudinal vessels passing from one extremity to the other, through all the segments, and toxic substances injected into the body of the worm are taken up by them and reach every portion of the parasite.

"The mistake is often made of simply prescribing some remedy with directions for the patient to use. Only a small percentage of successes can thus be expected.

"The only proper method of treating tapeworm is about as follows:

"The patient does not fast or have any preparatory treatment whatever, except that he eats no breakfast on the morning of the day of treatment. At about 9 A. M. he is given a dose of infusion of pomegranate, or, what is far better, of tannate of pelletierin, with one or two drops of croton oil. The patient should be kept at rest, generally under the personal observation of the physician, for two or three hours, when movements of the bowels will most likely occur and a whole or a part of the worm be passed. If only a part protrude, then the hypodermic should be used as above described."

LIQUID AIR.—A. C. White, *N. Y. Medical Journal*, writes of the application of this substance in medicine and surgery. Its effect on micro-organisms was studied; pure cultures of anthrax, diphtheria and typhoid bacilli were exposed to the action of liquid air, some in sealed tubes and some in direct contact, the germs apparently not being affected in any way by the extreme cold. About three-fourths of an ear of a rabbit was frozen, and a small piece of the tip was broken with the fingers without pain or hemorrhage. Within ten minutes after the withdrawal of the air the circulation was re-established, with hemorrage at the point where the ear was broken off. The ear remained perfectly normal for about five days, when it began to swell, and at the end of two weeks half of the frozen part had shriveled and dropped off. The author has used frozen air in the form of a spray, and by means of a swab dipped in the liquid. After external application the skin becomes anemic, and in less than a minute's time, by means of the spray, the part is frozen. Even after the tissues are thoroughly congealed the circulation returns in a few minutes, and there is no injury to the tissues providing the part is not at the end of an extremity, such as the finger-tip. Only a slight burning or tingling is experienced in the part, which is followed by complete anesthesia. The absence of hemorrhage in the frozen part is an advantage.

The writer has performed several operations with the liquid air as an anesthetic; in one case an infected bursa was cleaned out, and in another he opened up the palm of the hand. In operating he thinks it better to apply the liquid air intermittently, excepting, of course, where only a single incision is required. In varicose ulcers, chancroid and chancres, the liquid air was found to be an excellent application. In a number of cases of sciatica and of herpes zoster, one case of intercostal neuralgia, and one of facial neuralgia, liquid air has been tried. In every one relief was obtained. The liquid was applied to the spinal end of the nerve. In none of the nerve cases was the air used more than once, and in no case was the application severe enough to cause blistering or sloughing.

THE INDICATIONS, CONTRAINDICATIONS, AND DANGERS OF THYROID MEDICATION.—At a recent meeting of the Academy of Medicine of Paris, Francis Franck (*Revue de Thérapeutique Médico-Chirurgicale*, February 1, 1899) called attention to the dangers of thyroid medication, which he thought required us to be cautious in its use. He pointed out that coma, convulsions and death may follow massive injections of thyroid juice into an animal, and that Ewald, Langendorff, Gley, Haskover and others have testified to these poisonous properties; while Lanz has shown that it causes excessive acceleration of the heart, and Charrin that it caused rapid emaciation, Dale-James has shown that it is possible for it to cause glycosuria. All these symptoms have been developed in the lower animals, but in man vertigo, tachycardia, pain, and great feebleness have been produced, and even death has been caused by cardiac collapse. Two such cases have been reported by Murray, one by Thomson, and one by Vermerhen. While these facts do not prevent us from using thyroid, Francois Franck thinks it should make us very cautious about its employment; or, in other words, the fact is recognized that all remedies possessing much power can not be abused.—*The Therapeutic Gazette.*

TREATMENT IN THE EARLY STAGES OF ACUTE APPENDICITIS BY SALINE APERIENTS.—The treatment that Dr. Maylard proposes, in the *Glasgow Medical Journal* for March, 1899, in the early stages of acute appendicitis, is as follows: 1. Give copious warm soap and water enemata. 2. Administer hourly, until the bowels move freely, small teaspoonful of sulphate of magnesium dissolved in about two wineglassfuls of warm water. Apply hot linseed poultices to the right iliac fossa. 4. Feed on whey, chicken tea, meat jellies, etc.—*Ibid.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING,
New Orleans.

DIPHTHEROID ANGINA DUE TO THE FUSIFORM BACILLUS OF VINCENT.—In March, 1897, Dr. M. H. Vincent, in a communication to the French *Societé Médicale des Hôpitaux*, called attention to a particular form of angina characterized by a pseudo-membranous exudate situated usually on the tonsils, associated with fever and adenitis, resembling diphtheria in its clinical aspect. Microscopic examinations made of cultures taken from the exudate, however, showed invariably instead of the Loeffler bacillus a peculiar fusiform bacillus in large quantities which can not be stained by the Gram method.

Continuing his researches and observations on the subject, Vincent writes again in the February number of the *Archives Internationales de Laryngologie* confirming his former statements and reporting the experiences of other investigators. More than sixty cases of a similar nature have been reported, in all of which the fusiform bacillus was present in large numbers and was apparently the principal pathogenic agent in the affection. The germ, however, may be found in limited numbers in the normal saliva mingled with the various organisms to be found in the mouth. In the false membrane and deep in the mucosa it is found in pure culture. The disease is less serious in its nature than diphtheria, but a microscopic examination is necessary to differentiate it. Local treatment alone seems to be indicated.

EXAMINATION OF THE EAR AFTER SYMPATHECTOMY.—Lannois, of Lyons, has made some interesting observations on this subject in a paper read before the last meeting of the French Laryngological Society. While it has been well known that division of the cervical sympathetic in animals causes vaso-motor disturbances in the face, eye and ear of the corresponding side, little has been definitely learned of the effect that this operation has upon the human ear and its function. Lannois has had occasion to examine ten cases in which sympathectomy had been performed either for exopthalmic goitre or epilepsy. In all of these he noted, in addition to the redness of the face, dilatation of the conjuctival vessels, retraction of the eye and myosis, that that there was a vaso-dilatation and a distinct elevation of temperature locally. The congestion was also appreciable in the deep portion of the auditory canal, about the annulus tympanicus and handle of the malleus. In some there was more or less redness of the tympanic membrane. In four of the cases the author was able to recognize a marked vascularity of the tympanic mucosa. The duration of these phenomena was variable; in some cases disappearing in from ten to fifteen days and in others they were still visible at the end of four months. There was a noticeable tendency to trophic changes caused, no doubt, by the interference with the blood supply of the parts.

In three cases in which some deafness existed an appreciable improvement in audition was observed. In one subject operated for exopthalmic goitre the hearing was greatly improved in an ear which had been very badly damaged by an attack of scarlet fever. This was in a hysteric patient. Almost complete cessation of very severe tinnitus was the result in one of the cases. Further investigation in this line will probably bring to light some interesting facts in regard to aural reflex phenomena.—*Revue Hebdomadaire de Laryngologie*, etc.

Miscellaneous.

Inoculation of Animals with Syphilis.—Two recent writers claim to have successfully inoculated animals with syphilis. These results, if not conclusive, are of interest. Van Neissen (*Wein. Med. Woch.*, Nos. 11 to 14, 1899), from material obtained from condylomata and from the blood of syphilitic patients, claims to have cultivated a bacillus on agar and bouillon. This bacillus resembles sometimes that described by Lustgarten, and in some instances reacts to the same differential stains. Van Neissen inoculated four apes, one dog, one rabbit and three guinea-pigs, and states that the course of the disease in the inoculated animals was the same as that of human syphilis. There was a slight reaction, an eruption of sores on the skin, with a tendency to spontaneous healing, and affections of the lymphatic and nervous systems. On the other hand, the author failed to obtain culture reproduction of the contagium. The photographs given of the sores do not appear to be conclusive, and we may add that these sores were diagnosed as impetigo by another observer. Another paper on the same subject is by Adrian (*Archiv f. Derm. und Syph.*, February, 1899), who experimented on guinea-pigs, dogs and pigs. In the two former animals the results were negative, but in pigs signs appeared similar to human syphilis, both chemically and microscopically. Scrapings from a hard chancre inoculated into the abraded skin of the pig caused an eruption similar to a maculo-papular syphilis, both clinically and histologically.—*British Medical Journal.*

A Sanatorium for Consumptive Soldiers in America.—According to the *New York Medical Record*, the United States are taking measures to secure proper treatment for such of its soldiers as may become consumptive, orders having recently been issued authorizing Surgeon General Sternberg to establish a sanatorium for the treatment of officers and enlisted men of the army suffering from pulmonary tuberculosis at Fort Bayard, New Mexico. Henceforth enlisted men suffering from this disease will be transferred to the new hospital on the recommendation of medical officers of the army, and discharged soldiers so suffering, if entitled to the benefits of the United States Soldiers' Home at Washington, may be sent to the Sanatorium, by the Board of Commissioners of the Home. All this is as it should be. There are certain diseases, notable among which are phthisis and dysentery, which are not only common among soldiers, but by which they are apt to be permanently disabled, and it is to be feared that only too often the risk of suffering from these diseases is entailed upon soldiers by the conditions of the service. It always appeals to us as a matter of rank injustice that the country should wash its hands of such cases when they are no longer fit for service. No country can be expected to discharge its soldiers in the same condition as it enlists them. " Fair wear and tear " must always be allowed for; but consumption caught in barracks is not " fair wear and tear," and such cases should not be turned adrift.—*British Medical Journal.*

NURSES MARRYING DOCTORS.—Several of the New York newspapers, with nothing better to talk about, have been commenting upon the great frequency with which trained nurses in the larger hospitals marry medical men, arguing from this that either the nurses "flirt and carry on" to a degree incompatible with nursely dignity, or else that some of them enter the service with a special view to matrimony. Says the *Boston Medical and Surgical Journal*, by way of comment: "There is doubtless a certain amount of truth in this; for whenever a young man of prepossessing appearance is brought into daily and even hourly contact with a comely young woman, shown to advantage in a neat attire, who is not on principle averse to matrimony, there is always the possibility, *Dieu merci*, of a matrimonial sequel, and although a hospital ward is not an ideal *milieu* for Cupid's ravages, the very community of purposes and emotions paves the way for tenderer feelings." We must all thank the *Journal* for its able defence of the fair co-workers in the field of humanity; after all, another exemplification of Charles Lever's statement that "Propinquity is the best match-maker."

Medical News Items.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION met in Chicago October 3 to 6, 1899. The meeting was in every way a success, and social features added to the zest of the gathering. Addresses of welcome were made by Dr. H. Moyer, chairman of the committee of arrangements, and others.

Dr. Duncan Eve, president of the association, delivered his address on medical jurisprudence.

In editorial comment, the *Lancet Clinic* (Cincinnati) eulogizes the social features and emphasizes the numerous innovations at this meeting. These in nowise detracted from the success of the literary features.

The next meeting of the association will be held in Asheville, N. C. The following officers were elected: President, Dr. Harold N. Moyer, Chicago; first vice president, Dr. H. A. Cordier, Kansas City; second vice president, Dr. T. R. Collings, Hot Springs, Ark.; secretary, Dr. Henry E. Tuley, Louisville; treasurer, Dr. D. S. Reynolds, Louisville.

JEFFERSON MEDICAL COLLEGE formally opened its new buildings on October 2, in the presence of a distinguished gathering. Addresses were delivered by the president of the board of trustees, Mr. William Potter, Dr. Thomas Addis Emmet, Dr. Phineas L. Connor and Surgeon General Sternberg. A reception followed the exercises.—*Medical News.*

ARMY NURSES ARE IN DEMAND although there are some four hundred in the army. Since the beginning of the Cuban war there have been 1700 nurses in service. According to the *Medical News*, army nurses must be graduates of regular training schools. They have living and traveling expenses paid, thirty days' furlough yearly, and when assigned to duty in this country they receive $40 a month; if abroad, $50 a month.

A NEW HOSPITAL is being built at Manilla, to accomodate 2000 persons, which will be the largest army hospital owned by the United States.

INSANITY ON THE INCREASE IN ENGLAND AND WALES.—On January, 1, 1899, there were 105,086 persons adjudged insane, an increase of 3114 over last year. The greatest increase was found to have taken place among the paupers.—*Modern Medicine.*

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION will hold its next session in New Orleans, December, 5, 6, and 7. A good attendance is expected. No program has been issued yet, but members of the profession are cordially invited to attend.

THE ELEVENTH ANNUAL MEETING OF THE TRI-STATE MEDICAL SOCIETY OE ALABAMA, GEORGIA AND TENNESSEE was held in Chattanooga, October, 24, 25 and 26, 1899. The program was excellently arranged and the papers altogether valuable.

THE MEDICAL SOCIETY OF VIRGINIA held its Thirtieth Annual Session in Richmond, on October, 24, 25 and 26.

THE AMERICAN PUBLIC HEALTH ASSOCIATION will hold its twenty-seventh annual meeting at Minneapolis, Minn., October 31 to November 3. The program arranged for the meeting comprises a number of most important topics, as follows:

1. Pollution of water supplies. 2. Disposal of garbage and refuse. 3. Animal diseases and animal food. 4. Car sanitation. 5. Steamboat and steamship sanitation. 6. Etiology of yellow fever. 7. The relation of forestry to the public health. 8. Demography and statistics in their sanitary relations. 9. Cause and prevention of infectious diseases. 10. Public health legislation. 11. Cause and prevention of infant mortality. 12. Period during which each contagious disease is transmissible, and the length of time for which each patient is dangerous to the community. 13. Sanitation, with special reference to drainage, plumbing and ventilation of public and private buildings. 14. Method of international arrangements for protection against tha transmission of infectious diseases. 15. Disinfectants. 16. To examine into the existing sanitary municipal organizations of the countries belonging to the association, with a view to report upon the most successful in practical results. 17. Laboratories. 18. To define what constitutes an epidemic. 19. National leper

home. 20. Revision of classification of diseases. 21. Dangers to the public health from insanitary gas leakage. Dr. H. M. Bracken, Minneapolis, is the honorary secretary.

THE ILLINOIS STATE BOARD OF HEALTH, through a special committee, has urged the appropriation of $200,000 by the State Legislature for the establishment of an institution for the care of consumptives. It is stated that the project has the approval of the Governor.—*Journal American Medical Association.*

BOWDOIN COLLEGE WILL DIVIDE THE INSTRUCTION IN ITS MEDICAL DEPARTMENT HEREAFTER. The course is of four years, two years of which will be spent at Brunswick, the last two at Portland, where buildings are now being erected for clinic teaching and facilities.—*Medical News.*

THE FIRST ASEPTIC BARBER SHOP IN THE UNITED STATES is perhaps justly claimed by one Emile Cayé, in Baltimore. The following interesting rules, says *The National Barber*, are carried out for the "aseptic shave:"

1. Chair put in position, and gown properlv adjusted.
2. Razor is stropped, and then sterilized before using. Cup, shaving brush, hair brush and combs are sterilized each time after being used.
3. Hands are washed with castile soap—all soap is removed by rinsing with plain water; then the hands are immersed in an antiseptic fluid, and wiped on a sterilized towel.
4. Sterilized towels are taken from sterilized bag, and towel adjusted around customer's neck.
5. Sterilized cup and brush are used in making the lather, and then the barber proceeds to shave.
6. The face is washed with a sterilized towel—taken from sterilized bag.
7. Powder is applied on the face by dipping end of sterilized towel in powder box, and then rubbed on the face, and removed with end of sterilized towel. The towel is not to be redipped in powder after being once used.
8. Proceed to dress hair with sterilized hair brush and comb.
9. The barber's sleeves must be tight fitting, and about three inches above the wrist.

THE STATE BOARD OF HEALTH OF CALIFORNIA has decided not to quarantine against consumptives from other States, contrary to the general opinion conveyed recently.

HOIST BY HIS OWN PETARD.—A London physician gave a patient a tonic which the patient claimed made her ill. In order to assure her that it was not poisonous the doctor took several swallows of it. On arriving home he had a convulsion, and shortly died. Analysis showed that the bottle contained a large amount of strychnin, the doctor having used a solution of strychnin by mistake for chloroform water when compounding the medicine,—*New York Medical Record.*

MORE THAN ONE HUNDRED AND TWENTY-FIVE MILLIONS GRAINS OF QUININ have been taken by the United States' soldiers during the past year. Some of the sick soldiers in Cuba were given as much as three hundred grains a week for several weeks in succession.—*Medical News.*

DEATH FROM HEADACHE POWDERS.—A recent issue of the *Medical Standard* says that the coroner's jury attributed the death of a Pittsburg woman to use of a headache powder containing acetanilid. As there were five deaths from the same cause within a few months at Pittsburg, the druggists met and decided to sell no more acetanilid headache powders without previously attaching the caution.

SAN FRANCISCO PHYSICIANS HAVE STARTED A BLACK LIST, it is said, containing the names of the well-to-do who persist in refusing to pay the proper medical fees.

THE FIRST FEMALE PHYSICIAN ever permitted to practice was Elizabeth Blackwell, an English woman, born at Bristol, and a student in St. Bartholomew's Hospital in the fifties. She is still living and very proud of her place in the history of the medical profession. She worked in America through the Civil War.

THE "ANTI-SPITTING" LAW IN SAN FRANCISCO is being rigidly enforced against rich and poor alike. A prominent millionaire was recently arrested, tried and duly fined.

THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION held its ninth annual meeting in Washington, D. C. on September 19, 20 and 21, 1899. The convention was very successful in point of attendance and interest. The program included thirty-six papers and the reports of seven standing committees on scientific questions relating to the medical application of the electric current, with the best electric apparatus extant. The proceedings of the convention will be published at an early date.

The officers elected for the coming year are: President, Dr. Walter H. White, Boston, Mass.; First Vice President, Dr. Percy Hickling, Washington, D. C.; Second Vice President, Dr. Chas. O. Files, M. D., Portland, Me.; Treasurer, Dr. Richard J. Nunn, Savannah, Ga.; Secretary, Dr. George E. Bill, Harrisburg, Pa. The next meeting will be held in New York City in 1900.

The Governors of the New York Skin and Cancer Hospital announce that Dr. L. Duncan Bulkley will give a series of clinical lectures on diseases of the skin, in the Out-Patient Hall of the Hospital, Nineteenth street and Second avenue, on Wednesday afternoons, commencing November 1, 1899, at 4:15 o'clock. The course will be free to the medical profession.

Obituary.

Frank McShane, the Journal's messenger, died October 13, 1899. Everyone who came in touch with Frank's quiet, unobstrusive, way will miss him. Frank had always a directness of purpose and a conscientious faithfulness to detail which made him a part of the Journal for some seven years. His office was not a large one, but again we say that he will be missed, and to the editors and manager he will ever remain the emblem of duty, discipline, and devotion.

While ailing for some time, Frank's illness was not long and the end came with the quality which blesses.

Edward Aber, the noted Berlin Publisher, died recently at the age of 90 years. His long association with the leading medical men of the German metropolis makes his death notable, particularly as he was identified with the more important medical publications in Berlin for a large part of the last half century. He founded the *Berliner Klinische Wochenschrift* and brought it to its present vogue. At the head of the firm of August Hirschwald, in Berlin, Aber has published much of Virchow's best work on pathology. He founded different special journals on psychiatry and other subjects; also founding the *Zeitschrift für Klinische Medizin*, the *Centralblatt für die Medizinischen Wissenschaften* and recently the *Hygienische Rundschau.*

These were only a part of his relation to medical progress in literature, which included various hospital reports, the publication of the medical and surgical records of the war office, etc.

In the breadth of his medical associations he was looked upon as a veritable *index medicus* in the "Athens on the Spree."

Book Reviews and Notices.

On Cardiac Failure and its Treatment, with Especial Reference to the Use of Baths and Exercise. By ALEXANDER MORISON, M. D. (Edin.), F. R. C. P. (Edin.). The Rebman Publishing Co. London. 1899.

The seekers after truth are invited here to a comparatively novel problem. Both as an advocate and a guide the author is most assuredly capable of maintaining the attention his book attracts on sight, for reading of theories and facts presented in such a clear and spirited style as his removes all obstacles in the way of quick assimilation and persuasion. But the difficulty lies not in the pleasant duty of learning the method and having the details at one's finger-ends, it is all in the practice of it, everywhere. Now, from education and habit, or second nature, physicians are willing not only to be taught and kept well informed, but also overtasked at a great sacrifice of time and earnings. The disappointing questions are the following: The other party, the patient; his unflinching assistance, at least morally; the facilities and accommodations for carrying out such a treatment. At any rate, as a matter of gaining information and knowledge, with sincere hopes of practicing the method some time, this thoroughly scientific, well-written, well-printed and well-illustrated book is worth having.

DUPAQUIER.

The Medical Complications, Accidents and Sequelæ of Typhoid or Enteric Fever, by HOBART AMORY HARE, M. D., B. SC., with a special chapter on the mental disturbances following typhoid fever, by F. X. DERCUM, M. D., etc. Lea Brothers & Co., Philadelphia and New York, 1899.

It would be difficult to find a more classic subject, one that necessarily deserves more attention than this on the part of practitioners. Typhoid fever is so widespread and atypic cases so puzzling that this book can not fail to be welcomed by the profession

The merit of the author of this remarkable essay is that he completes the rudimentary articles of text-books, in which it would be a downright impossibility to include all the data on so voluminous a matter.

However huge it may seem, the work has been performed with a happy issue without leaving room for criticism. It does credit to the author, one of our representative American writers.

The book in its material form, presswork and illustrations, is equally worthy of praise. DUPAQUIER.

Diseases of the Nose and Throat, by CORNELIUS G. COAKLEY, A. M., M. D. Published by Lea Brothers & Co., New York and Philadelphia, 1899.

This work is in the form of a manual intended for the use of students and general practitioners. The author has confined himself to a consideration of those methods that are the most practical for diagnosis and treatment, and recommends those that are employed in his own practice with the best results. A valuable feature of the book is the part devoted to the study of special therapeutics and formulæ, and furnishes some very practical suggestions to those who have not had the benefit of clinic experience in this branch of medicine. The text is systematically arranged, clear and concise, and comprises all subjects important to the beginner.

DEROALDES AND KING.

Minor Surgery and Bandaging. By HY. R. WHARTON, M. D. Lea Brothers & Co., Philadelphia and New York, 1899.

The fourth edition of Wharton's book on Minor Surgery and Bandaging has just been presented to the profession. The previous editions of this little manual are too well known to need extolling. The present work, like its predecessors, is fully up to date. It is not only valuable to the student, but recommends itself especially to the young practitioner and country physician who may be called upon in emergencies to perform operations of rare occurrence. The present edition will undoubtedly increase the popularity of this book. MARTIN.

PUBLICATIONS RECEIVED.

Lea's Series of Pocket Text-Books; Materia Medica, Therapeutics, Medical Pharmacy, Prescription-Writing and Medical Latin, by William Schleif, Ph. G., M. D., edited by B. B. Gallaudet, M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

A Text-Book of Physiology, by Winfield S. Hall, Ph.D., M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

The Nervous System and Its Constituent Neurones, by Lewellys F. Barker, M. B., *Tor.*—D. Appleton & Co., New York, 1899.

A Compend of Gynecology, by William H. Wells, M. D.—P. Blakiston's Son & Co., Philadelphia, 1899.

Surgical Anatomy—A Treatise on Human Anatomy in Its Application to the Practice of Medicine and Surgery, by John B. Deaver, M. D. Volume I.—P. Blakiston's Son & Co., Philadelphia, 1899.

Transactions of the Texas State Medical Association. Thirty-first Annual Session, 1899; H. A. West, Secretary, Galveston, Tex.

Informes Rendios por los Inspectores Sanitarios de Cuartel y los de los Distritos al Consejo Superior de Salubridad de 1898.—Mexico, 1899.

College Announcements: The Playfair School of Midwifery, 1899. *The Philadelphia Polyclinic and College for Graduates in Medicine*, 1899.

REPRINTS.

Carcinoma of the Duodenum.—The Diagnostic Value of Abdominal Palpation in Diseases of the Intestines.—Simple Method of Administering Hydrochloric Acid, by Charles D. Aaron, M. D.

The Other Side of the Antitoxin Question.—The Failure of Antitoxin in the Treatment of Diphtheria, by J. Edward Herman, M. D.

Epistaxis Spontanée—La Parole—Paris.

Constipation—Its Treatment by the Mechanical Measures, by H. Illoway M. D.

Methods and Results in 175 Cases of Simple Fracture of the Femur.—Methods and Results in 450 Cases of Fracture of the Fore-Arm Bones, by Charles A. Powers, M. D.

Progress in Gynecology.—True Conservatism in Gynecology—Operations During Pregnancy—The History of the Early Operations for Fibroid Tumors—Alexander's Operation, by Charles P. Noble, M. D.

The Forcible Straightening of Tubercular Kyphosis, by Justin Kay Toles.

A Further Report on the Use of "Antiphthisic Serum, T. R. (Fisch) In Tuberculosis, by A. Mansfield Holmes, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR SEPTEMBER, 1899.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	5	4	9
" " Intermittent			
" " Remittent	2		2
" " Congestive	7		7
" " Typho	1	3	4
" Yellow	6		6
" Typhoid or Enteric	12	6	18
" Puerperal			
Influenza			
Measles			
Diphtheria			
Whooping Cough	1		1
Apoplexy	7	7	14
Congestion of Brain	2	1	3
Meningitis		2	2
Pneumonia	7	5	12
Bronchitis	5	2	7
Cancer	10	1	11
Consumption	46	35	81
Bright's Disease (Nephritis)	18	17	35
Uremia	3		3
Diarrhea (Enteritis)	10	5	15
Gastro-Enteritis	1	3	4
Dysentery	2	4	6
Hepatitis	3		3
Hepatic Cirrhosis	6	1	7
Peritonitis	2	1	3
Debility, General		1	1
" Senile	15	15	30
" Infantile	3	3	6
Heart, Diseases of	40	19	59
Tetanus, Idiopathic			
" Traumatic		3	3
Trismus Nascentium	5	10	15
Injuries	11	7	18
Suicide	2		2
All Other Causes	81	42	123
TOTAL	313	197	510

Still-born Children—White, 21; colored, 10; total, 31.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 17.88; colored 25.82; total, 20.40.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.04
Mean temperature	77.60
Total precipitation	.035 inches

Prevailing direction of wind, north.

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Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

THE MUNICIPAL CONTROL OF PROSTITUTION IN THE UNITED STATES. SOME OPINIONS AS TO METHODS ADAPTED TO MUNICIPAL CARE AND CONTROL OF PROSTITUTION AND FOR THE PROPHYLAXIS OF VENEREAL DISEASES.*

BY ISADORE DYER, M. D.

PROFESSOR ON DISEASES OF THE SKIN IN THE NEW ORLEANS POLYCLINIC; MEMBER NEW YORK MEDICO-LEGAL SOCIETY; DELEGATE TO THE BRUSSELS CONFERENCE ON THE PROPHYLAXIS OF SYPHILIS, ETC., NEW ORLEANS.

While thoroughly satisfied that the whole of the United States were almost entirely without system of control, so far as prostitution and venereal diseases were concerned, it nevertheless seemed advisable to make an exposé of this fact by tabulating and presenting a series of statistics obtained from representative cities; such statistics to be based upon the same lines of inquiry as those submitted by the Conference committee, but expanded so as to meet conditions in this country.

All cities in the United States of 20,000 inhabitants and over were addressed by circular sent to the mayor, health officer or chief of police of each; in most instances all three officials were requested to furnish the information desired. Where the geographic situation of a city dictated its importance, cities of less than 20,000 inhabitants were likewise solicited.

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* A paper prepared for and presented at the International Conference for the Prevention of Syphilis and Venereal Diseases, held in Brussels, Belgium, September 4 to 8, 1899.

In some instances much interest was evoked by the circular of inquiry and a willingness to better existing conditions was expressed.

In most cases, however, bare facts were submitted, frequently without comment, while in a large proportion of those cities addressed by circular, no answer whatsoever was vouchsafed.

To more clearly present the information received, we have arranged below each of the questions submitted together with the several kinds of answers received to each of these: The number of cities giving each answer is also stated:

QUESTION I. *Is prostitution in your city unrestricted, or under surveillance?*

Unrestricted, 11.

Under surveillance, 34.

Restricted, 2.

Prohibited, 12.

Unrecognized, including those cities whose conditions were not known, or were not investigated, 9.

QUESTION II. *How many houses of prostitution are there in your city, and III,* HOW MANY PROSTITUTES?

Cities having no houses, 8.

Cities which could give, or did give no information, 20.

Cities having street walkers, but no houses, 1.

Cities having no means of knowing, 1.

City having great number, but number not given, 1 (Rochester, N. Y.).

List of cities showing number of houses and number of prostitutes:

Name of City.	No. of Houses.	No. of Prostitutes.	Information Obtained From.
Albany, N. Y.	15	†	Mayor's Office.
Atlanta, Ga.	20	150	Hon. J. G. Woodward, Mayor.
Auburn, N. Y.	2	8	Robert A. Dyer, Esq., Registrar.
Aurora, Ill.	none	‡	John McDonald, M. D. Health Officer.
Baltimore, Md.	350	1,000	A. K. Hadel, M. D., Sec. B'd of H'lth.
Bay City, Mich.	§15	§80	Andrew D. Wyman, Esq., Supt. Police.
Birmingham, Ala.	25	‖250	Hon. R. H. Kerr, Mayor, and W. R. Wilder, M. D., City Physician.
Cincinnati, Ohio	275	1,200	Health Dep't, Mayor's Office, and Supt. Police, Phil. Deitoch, Esq.

Name of City.	No. of Houses	No. of Prostitutes.	Information Obtained From.
Cleveland, Ohio	60	200	Not stated.
Danbury, Conn	none	12	G. E. Lemmer, M. D., Health Officer.
Davenport, Iowa	14	34	Hon. Geo. T. Baker, Mayor.
Dayton, Ohio	38	57	C. A. Bonner, M. D., Health Officer.
Des Moines, Iowa	40	¶	Fred. J. Wells, M. D., Physician to Board of Health.
Elmira, N. Y	5	25	H. D. Wey, M. D., Health Officer.
*Erie, Penn	8	210	J. W. Wright, M. D., Health Officer.
Indianapolis, Ind	150 to 200	*a*1,000	Dr. A. W. Brayton, Editor *Indiana Medical Journal.*
Lincoln, Neb	10	49	H. V. Hoagland, Esq., Chief of Police.
Memphis, Tenn	25	125	The *Memphis Lancet.*
Minneapolis, Minn	35	1,000	A. K. Norton, M. D., for Police and Health Departments.
Mobile, Ala	45	no rec.	Police Department.
New Albany, Ind	none	25	Wm. Adams, Esq., Sup't Police.
New Britain, Conn.	2	10	Robt. M. Clark, M. D., Chairman Health Committee.
New Haven, Conn	6	*b*	Jas. H. Townsend, Esq., Pres. B. of H.; Frank W. Wright, M. D., H'lth Officer; James Merwin, Supt. Police
NEW ORLEANS, LA.	**290**	**2,000**	Hon. W. C. Flower, Mayor, and D. S. Gaster, Esq., Chief of Police.
Newark, N. J	25	100	Not Stated.
New York City	1,500	60,000	Mrs. E. M. Whittemore, Pres. of the Door of Hope, etc.
Philadelphia	*c*	*c*	Orville Horwitz, Esq., Dep. Pub. Safety
Quincy, Ill.	25	100	Geo. Degitz, Esq., Sec. B'd of Health
Sacramento, Cal	20	40	Hon. Mayor Land.
Salt Lake City, Utah	15	100	Eli A. Folland, Clerk Board of H'lth.
Schenectady, N. Y.	none	10	Wm. L. Campbell, Esq., Chief Police
Seattle, Wash	13	190	W. E. A. McKechnie, M. D., H. Officer
Selma, Ala	10	30	B. B. Rozan, M. D., City Physician; Percy Dawson, Esq., Chief Police.
SHREVEPORT, LA	15	125	J. C. Egan, M. D., Health Officer.
Spokane, Wash	40	65	W. M. Potter, M. D., Health Officer.
St. Paul, Minn	19	400	Ernest Boerner, Esq., Lieut. Police.
Superior, Wis	7	20	Mayor, Hon. H. W. Dietrich.
Syracuse, N. Y	30	300	Hon. Jas. K. McGuire, Mayor.
Trenton, N. J	72	100	Dr. A. S. Fell, Health Officer.
Utica, N. Y	12	40	Wallace Clark, M. D., Health Officer.
Wheeling, W. Va	25	150	S. L. Jepson, M. D., Health Officer.
Wichita, Kansas	12	60	J. W. S. Shults, M. D., Pres. B. of H.
Williamsport, Penn.	none	100	C. W. Youngman, M. D.
Zanesville, Ohio	15	75	Hon. L. E. Brelsford, Mayor.

Total No. of Cities 44. Total No. of Prostitutes 69,440.
Total Population of these Cities 7,684,938 (excluding Philadelphia).
d Comment: 1 Prostitute to every 110 Inhabitants.

* DEAR DOCTOR—Your circular letter of May 1 at hand. From the fact that prostitution is prohibited by our State and city laws, it is impossible to give satisfactory replies to many of your questions. As the subject is one of vital interest, I have enclosed a clipping which will explain conditions existing in this city up to April 1, 1899. Since that time, however, attempts have been made by the authorities to enforce the prohibitory laws, and as a result, clandestine prostitution has greatly increased with a corresponding augmentation of venereal diseases.

Very truly yours,
J. W. WRIGHT.

† Not given.
‡ Street walkers only.
§ Registered.
|| Whites, also negroes, not estimated.
¶ Not known or estimated.

a Estimated.
b Chiefly street walkers, numbers not known.
c Keeps no record.
d Estimates for example, not because

QUESTION IV. *What are the Existing Laws Regarding Prostitution?*—In no instance (except in New Orleans) were these furnished. The information obtained can be tabulated as follows: Of 68 cities, 20 had no laws; 12 had State law; 32 had prohibitory laws; 9 had license or exacted fine; 3 fixed the location of the houses and of prostitutes to certain districts; 1 city rings curfew bell at 9 P. M., requiring prostitutes to be in doors; 2 cities occasionally raid houses, and 2 others occasionally arrest for the effect produced; 2 cities have law to suppress; 1 to restrict, while 1 city has no legal recognition of prostitution, and 1 states that the condition is tacitly tolerated.

With regard to these laws and their enforcement (QUESTION 5), the following was deduced:

Strictly enforced	13
Moderately	21
As far as possible	2
After a fashion	1
Rarely	1
Not enforced	6
Not at all enforced	2
No law	5
Police regulation applied	1
Don't know—no information given or to be had	14

QUESTION 6. To the query: *Do these laws meet all requirements?* the following answers were given: No, 13; doubtful, 1; would if enforced, 1; they satisfy public opinion, 1; they cause abatement of evil, 1; effective in degree, 1; yes, 12; don't know, 13; no answer, 5.

QUESTION 7. Thirty-four cites say *no former laws* existed; seven cities that laws did exist; eleven cities don't know; sixteen did not answer.

The questions which follow are more directly applied to the points of prophylaxis of venereal disease and the mere presentation of the questions and answers will show a striking condition of affairs.

QUESTION 8. *How and by whom are prostitutes examined?*

Not examined, 35.

Not officially examined, 6.

Examined by City Physician, 1.

Private examination, 11.

Don't know, 6.

No answer, 9.

QUESTION 9. *Are secretions examined for gonoccocci?*

All cities answered in the negative, or not at all.

QUESTION 10. *What evidences of efficiency are required of physicions charged with this service?*

(See Question 9.)

Only one definite answer, viz.: Must be regular graduated physician. All other cities either answered that there was no provision, or no answer was given.

QUESTION 11. *What records are kept of prostitutes?*

None, 31.

No answer to request, 7.

Board of Health register, 1.

Police records, 28.

QUESTION 12. *From what class of society do most of them come (factory girls, shop girls, nurses, maids, leisure classes, native born, foreign born, etc.)?*

No answer, 19.

Don't know, 7.

Lower classes, all classes, native born, negroes, respectable country homes, factory girls, traveling class (migratory prostitutes), leisure class, servant girls, dressmakers, native born, independent of occupation, shiftless women, German Jews, Irish, foreigners, shop girls, each 1.

QUESTION 13. *What are, in your judgment, the usual local or general influences driving them to prostitution (poverty, stress of times, seduction, criminal environment, criminal proclivities, etc.)?*

Don't know, 5.

No answer, 18.

No data, 1.

Neglectful parents, poverty, *seduction**, hard times, *criminal environment*, criminal proclivities, *love of dress*, *love of the life*, idleness, want of work, unhappy homes, no cause, just for fun, homeless, all causes, pleasure and profit, ignorance, all night dances, curiosity.

QUESTION 14. *What is the average age of registered prostitutes, and how long (as an average) have they followed this trade?*

The information derived from the few answers to this question is of practically no value because of its meagerness. From the data given the average age of prostitutes would be 27½ years; the average period of life at this trade, 6½ years. No information was furnished from 50 of the 68 cities named as giving other information, and the information given apparently was given upon surmise or conjecture, and not upon fact.

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*NOTE—Those italicised were the more frequent causes given.

QUESTION. 15. *What percentage of prostitutes are minors?*

Of 14 specific percentages given, the lowest gave 5 per cent , the highest was 80 per cent. ; the average of these was 29⅓ per cent. No answer was furnished by 15 cities. Other cities gave the following information:

None minors, 9.
Very few, 10.
Don't know, 18.
Almost all minors, 3.

QUESTION 16. *Are there any institutions in your city for preventing the seduction af minors?*

No answer, 11.
No institution, 46.
Yes, 11. (Of these one city has three institutions; six cities have one institution, the other two cities do not give the number of such institutions).

QUESTION 17. *Are there any houses of refuge for repentant women.*

No answer, 9.
No such houses, 29.
Yes, 30. (Of these, fifteen cities have one house of refuge; one city has two houses; one city has three houses; one city has one house for pregnant women only; the other twelve cities, gave no specific information).

QUESTION 18. *What is the age of consent in your State?*

This information was compiled and the average was found to be 16; Some States have no statute, while the lowest age of consent is 14; in Louisiana the age is 17.

QUESTION 19. *Is there any recognition of clandestine prostitution in your city?*

Not officially, 1.
Not recognized, 40.
Yes; recognized, 8.
Not answered, 19.

QUESTION 20. *Are houses of assignation licensed or permitted?*

Not lawfully, 2.
Not permitted, but exist and are overlooked, 5.
Licensed, 1.
Not licensed, but permitted, 1.
Permitted by registering, 1.
Permitted and fined or licensed, 4.
Permitted under police regulation, 1.
Permitted, 10.
Fined monthly, 1.
Not permitted, 31.
No answer received, 11.

QUESTION 21. *Are procurers or procuresses punishable?*

All cities state that such individuals are punishable; some state that the regulation or law is occasionally enforced.

QUESTION 22. *Are there any restrictions as to the locality of residences of prostitutes?*

Yes, 21.
No, 22.
No answer to question, 19.
Self localized, 2.
Not except by custom, 1.
Not except by complaint of neighbors, 1.
Prohibited entirely, 2.

QUESTION 23. *If there is a law requiring medical examination, does this take place at the houses of prostitution or at some central hospital or other institution?*

NO SUCH LEGISLATION OR REGULATION EXISTS IN THE UNITED STATES.*

QUESTION 24. *Are those prostitutes found to be diseased compelled to remain at the hospital or are they treated at home?*

No compulsory treatment in the United States. They stay where they wish, usually are treated domiciliarily.

QUESTION 25. *Are records kept of venereal diseases?*

All cities questioned answer in the negative.†

QUESTION 26. *How many cases of syphilis were reported in 1898?*

None reported from any point. (See note Question 25.)

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* San Francisco, Cal., San Antonio, Tex., and St. Louis, Mo , have tried to enforce such a regulation but not effectually.

†Note—In justice to special students of syphilis and venereal diseases, it should be said that careful hospital statistics are kept by the special surgeons in charge, e. g., notice our report on venereal diseases in New Orleans.

QUESTION 27. *What percentage of, or how many cures?*

No record obtained.

QUESTION 28. *Is there any relation between the number of prostitutes and the number of cases of syphilis?*

No records given—impressions are positive.

QUESTION 29. *In the absence of exact statistics, what is your impression as to the augmentation or diminution of venereal diseases?*

Increase, 18.
Diminution, 13.
About the same, 1.
No answer to question, 30.
Don't know, 6.

QUESTION 30. *What part of the propagation of venereal diseases is due to:*

(*a*) Regular prostitution?
(*b*) So-called clandestine prostitution?
(*c*) Other methods of contamination?

The consensus of opinion of all answers goes to show that by far the greater part of venereal diseases are due to clandestine prostitution; much less to regular prostitution, and that other methods bear an insignificant part in the question.

QUESTION 31. *Are there any hospitals with special services or out-clinics for the treatment of venereal diseases?*

To this question either no answer was given or it was stated that these cases were treated in the general clinics or hospitals without discrimination. The information was given that in five cities especial provision was made for venereal cases. In most of the larger cities this is true. In New York City, for example, there are special venereal clinics at the Bellevue, Roosevelt, New York, and other hospitals, while at Bellevue and the City (formerly Charity) Hospitals there are special wards for these cases. Like provision is made in Baltimore, Philadelphia, Boston, etc.

Statistics at best are only guides to formulated opinions, and even if the above were more explicit they could in nowise create other than the one impression, *q. e.*, that *there is a woful lack of municipal supervision, knowledge and control of prostitution and venereal diseases in the United States.*

When New York, Philadelphia and Baltimore have no system of control or proper registration, and when Chicago does not furnish even any information at all, the question is really open for study.

Even though police regulations do exist, and are fairly well enforced (as in Bay City, Michigan, and in Erie, Pennsylvania), these do not fulfil the requirements of to-day.

Not one of the cities listed as invited to co-operate in the acquisition of information has been able to furnish any information regarding venereal diseases. All opinions formulated by the health officer, police official or city mayor or clerk, have been drawn altogether from personal conviction or else from the merest impression.

In most of the replies furnished with any comment, there have been found expressions of interest in the question and of a desire to be informed of ways and means of enlightenment.

The impression which stands out most strongly to the author is that of *the general public indifference to the question of prostitution*, and the fact that it is relegated in almost all cities (only one of those heard from excepted) to the police department, and *is classed with vices, crime and nuisances.*

The study of prostitution is as interesting as it is outlawed, and whenever a man or woman has ventured to discuss its phases in the public press, the majority of persons are affronted and shocked at the display.

This has probably more than anything else reduced prostitution to its present grade of outlawry.

From the sociologic standpoint prostitution must either be tolerated or it must be prohibited.

Toleration means a degree of protection to the home at the hands of the male sensualist, who thus has an outlet for his passion and appetite.

Prevention or prohibition of prostitution will not put a stop to the evil, and experience has demonstrated that legislation directed at such ends results in increased clandestine prostitution. As this means increased venereal infection, the two questions are alike dependent upon a proper recognition of the evil of prostitution, and amelioration of both conditions can only be accomplished by some systematic attempt at the tolerant recognition of the one and the provision for the prevention of the latter.

In another paper* submitted to the Conference I have taken up

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*To be published in the *Philadelphia Medical Journal.*

the two questions purely from my own point of view, and not with much of practical suggestion, as I preferred to bring this in more direct application to the questions as they are represented as occuring in this country.

Spasmodic efforts have been directed at the control of prostitution in the United States, but always either at the hands of religious fanatics or else social reformers posing for political gain.

In Pittsburg, Pa., in 1891, the houses of prostitution were closed, the inmates turned out upon the streets and were refused lodging and even food by the citizens of that place. All over the country a wave of popular remonstrance at the outrage on humanity soon created a reaction which resulted in a last condition by no means better than the first.

In the same year and throughout 1892 a minister of the gospel, one Parkhurst, decided to reform New York and began by having the locality (by common consent set apart for the prostitute class) cleaned out. At the end of a very few months he accomplished his purpose, but by spreading the locality over an area of New York several times as great as it had been, and additionally filled the thoroughfares with street-walkers and soliciting prostitutes, formerly housed.

The reform failed naturally, because the method was not based upon a logical or sane plan of action.

Some cities of the United States have recognized the evil and the necessity for it, and have tried to make it as little evident as possible. This has been accomplished by restricting the traffic to definite localities and by compelling inmates of brothels to remain in their districts. San Antonio, Texas, is an example of this class of cities.

There should be some uniform method adopted by large and small cities in the United States, and if there were some concert of action, the method would improve until it could be made effective.

We believe it is out of the question to adopt prohibitory laws, because such legislation only makes the study of the evil the harder, because its victims become the more clandestine and secluded.

More than this, prohibitory laws are not enforced, and even the pretence of their fulfilment puts a premium upon dishonesty, for even the better class of the officials of to-day are often open to a bribe.

That some method must be adopted is, however, clear, for—

1. There is at present almost universal absence of active regulations governing prostitution in most of the cities and States of the United States; the houses of prostitution and their inmates are recorded by the police in some cities, but even then the records are incomplete; no information is kept by the authorities upon the question of venereal diseases among the prostitute class.

2. The absence of statistics and the lack of provisions for determining and recording and treating venereal diseases in this class in large degree create the general indifference to existing conditions.

3. While the health authorities are busied with the study of other contagious diseases, such as diphtheria, scarlet fever, variola and the like, the venereal diseases are not even considered, although their occurrence is really greater in proportion to population than most of the diseases studied by them.

In order to accomplish reform, some general understanding should be had of the exact status of first, prostitution, and second, venereal diseases in their relation to the public, and whether their control and investigation should be placed under police or health control.

Heretofore, we have seen that prostitution has been purely a question of police record and supervision, and that heretofore venereal diseases have occupied (in the United States) no position so far as the public has been concerned. We need not review the detailed statements of insane asylum superintendents to remember the evils of syphilitic infection of the innocent; nor do we have to more than mention the host of suffering women, blighted by a souvenir of a neglected gonorrhea—all arguing, if the public were really educated to it, that *there is some need of protection from, and of prevention of venereal diseases.*

With an autocratic government, a commission to study, investigate and suggest laws for the control of prostitution and the prophylaxis of venereal diseases could easily be directed and its work consummated. But in the United States, each State is sovereign in its right to control and regulate the conditions within its confines, and it would be far more difficult to get uniformity of action.

Any method or system for a reform must be simple in order that it should appeal to the constituted authorities.

We believe that *prostitution should be tolerated, should be licensed, and should be recognized as a necessity to a civilized community, so long as laws are made differently for men and women.*

If no restriction is put upon the male sexualist, who seeks women, then no *criminal* restriction should be put on women of this class, who are usually as much sinned against as sinning. Once licensed, the license to be determined by the size of the community and the estimated need for funds for this department of the public health, this class of society should be made amenable to such laws and ordinances as govern other citizens.

This opens the way to a natural reform, a thing impossible when the followers of the life of prostitution are classed, *ipso facto*, as offenders.

1. *A police record should be kept* of all houses, suspected houses, assignation houses, with the number of inmates, their names, ages and previous condition, with such other information as may be had. A like record should be filed by the police authorities at the office of the municipal health department. Where possible the history of every inmate should be obtained; birth place; former residences; years at such life; occasion of fall; whether diseased at any time; if ever arrested; heredity. viz: as to occupation and habits of father and mother, particularly with reference to drunkenness or crime; if other members of family have been engaged in the same life.

2. *There should be a systematic supervision* of residences, regular houses or not, by police or other officials, to insure the observation of regulations, to record removals, etc.

3. There should be a *regular police inspection and record of public resorts* frequented by this class; saloons, cafes, gardens and the like, with special reference to arrests made at such places, etc.

We believe it would be well to establish a special division of the municipal health department to accomplish the above, particularly with a view to obtaining the desired information which may be and is very apt to be misleading when collected by the average policeman, whose intelligence usually stops at words of three syllables.

In time this would bring the whole question under health department supervision, and the license fees could be made to defray the expense of special officials, and also the contingencies or the office, and provide as well for future expansion of the purpose of that office.

This would make the following conditions easier. These, however, would properly belong to the bureau of vital statistics or sanitation, in which division of the health department they should be kept.

Although requirement would not be possible, yet physicians in charge of public clinics should be glad to give desired information, and private physicians could gradually be educated to the advantage of supplying information regarding venereal diseases.

On this basis of presumption the following plan is suggested:

1. *A monthly circular blank* should be sent to each practicing physician in city and State with the request that he report upon cases of syphilis and venereal diseases in his practice; the circular to be arranged somewhat as in the following table (*see page 320*).

There would be very little difficulty in compiling records from such tabular reports, which could be expanded as required or desired.

There should be provision made for the hospital care of prostitutes and venereal cases along several lines:

1. *Regular examination*, NOT UNDER POLICE REGULATION NOR COMPULSORY, but under some *voluntary* system. This would provoke a desire for well-being among prostitutes if the examination could be conducted with some degree of privacy. This could be accomplished under the direction of the city health office, through a regularly appointed medical inspector, who could visit each house at regular intervals and who could be paid by the city from the funds derived from licensing keepers and inmates of houses. This would only increase the precautions which those women already exercise themselves; for most of the more respectable and more prosperous houses have private examiners at regular intervals, or else the women themselves go to the offices of physicians for such examination. For

* (PRIVATE) PUBLIC PRACTICE,

Meaning Hospitals, Dispensaries or City Service.

	MALES.		FEMALES.		TOTAL.
	White.	Black.	White.	Black.	
A. SYPHILIS—					
Character of Syphilis:					
Chancre: Genital					
" Extra genital					
Mild eruptions on body					
Ulcerative and destructive lesions on body					
Total					
Number of prostitutes					
Number suspected of clandestine intercourse					
Number supposedly innocent					
B. GONORRHEA—					
1. Acute					
Youths and boys (*i. e.*, under 21)					
Men					
2. Complications directly traceable to gonorrhea					
Total					
Prostitutes					
Suspects					
Innocents					
C. CHANCROID—					
Prostitutes					
Suspects					
Innocents					
D. LOCAL VENEREAL LESIONS—					
1. Ulcers					
2. Herpes following venery					
3. Warts					
4. Abrasions					
5. Miscellaneous					
Total					
Prostitutes					
Suspects					
Innocents					

*Draw a line through the class of practice not reported.

the others, by far the more dangerous classes from the point of infection, some system of hospitalization should be adopted. First, an office to which these women could come for examination; and second, indoor provision for the treatment of those diseases.

A *St. Lazare** could not exist in the United States under public regulations, but special hospitals could and would if seclusion and the assurance of good care were afforded. Few hospitals in the United States make provision for venereal cases, other than for those absolutely incapacitated. It is the rule at the New Orleans Charity Hospital, a type of the best hospitals in this country, *to refuse indoor treatment to ambulant cases* of gonorrhea and syphilis and their complications, and acute cases are constantly turned away, with a prescription or two, half the time given to those too poor or too ignorant to use them intelligently.

Hospitalization is, to our mind, a *sine qua non* of the prevention and control of syphilis and venereal diseases. It is segregation, sanitation and quarantine, and provides the surest means of relief. Besides, the hospitalization of one case is the certain prevention of a score of new infections.

The following instances are quite in point:†

I.

"Miss May, a prostitute twenty-three years of age, consulted me in August, 1891. She had a chancre of the urethra. I advised rest from her occupation, but was told on my next visit, two days later, that she had entertained seven men during the previous night. Four weeks from this date, a traveling salesman, thirty-six years of age, married, consulted me. He said he had visited my patient, Miss May, about a month ago, and had contracted a disease. He was afraid he had inoculated his wife, and arranged to bring her to my office for examination. I found, upon examination, two well-developed chancres of the right labia, and a pregnant womb. Six months later she gave birth to a seemingly healthy child. Ten days later I was called to see the babe, and was told by the mother that it had scarlet fever. I found the temperature 104 deg. F., and the body covered with an eruption. The usual syphilitic treatment seemed to improve the patient until the end of the third week, when I was again summoned because the child could not open its eyes. An oculist was called, and the child was treated for syphilitic conjunctivitis.

Until forty-eight hours previous to this visit, the child's eyes seemed to be free from disease, and the mother thought it had taken cold while on a visit to her parents. I heard no more of the case for four years, until about a year ago, when the father consulted me again, but not professionally. He wanted me to refer him to some one who would put the child into a blind asylum, to be cared for until it could care for itself. He had lost his turbinated bones and his position on the road. His wife, who seemed well before the birth of her child, was now bedridden, after undergoing ovariotomy.

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*The municipal hospital of Paris for prostitutes having venereal diseases, to which they are compelled to go when found on examination to be diseased.

†Dr. Luella Day-Underhill.—*Modern Medicine*, 1896.

Now if Miss May had been quarantined when I visited her the first time, might not this wife and child have escaped this disease? If so, is not every man and woman who has a voice in goverment affairs morally responsible for this condition?

II.

Another patient with primary syphilis refused even charitable treatment, and carried a book wherein she kept the number of men that she had inoculated. When I last saw her, she declared the number had reached 219, and that she would not be treated until she had had revenge on 500 men.

What can we as intelligent men and women mean by allowing such parasites to run at large? I have practised medicine fourteen years, and have been chairman of the police committee of the Illinois Woman's Alliance for the past two years. I have had untold experiences with this class of women. I believe that examination, and quarantine until the inoculation stage is passed, would protect innocent wives, and save thousands of children yet unborn from coming into this world with syphilis, the only legacy that many of them will inherit from their parents."

In the United States, as we have already stated, compulsory hospitalization can not prevail, except under a voluntary system. That is to say: a patient applying for treatment might be refused treatment except under hospital indoor care. If this were made the rule, and as I believe the practice is now being carried on in Leipsig, these patients would go elsewhere or go without treatment, but in time the rule would prevail.

Among the lower classes and among negroes in the Southern States this would be far easier in application than at first might seem. The negroes would be only too glad to avail themselves of hospital care and all this entails. Even now they frequently beg the indoor treatment which is at present refused them. Such hospitals must come from the city or State, for private endowment is chary of protecting against or of providing for the results of vice or indiscretion. Education is too slow to act until the philanthropic public is made to see how much more good they might do themselves by establishing such institutions than by buying memorials to their names in other lines.

The *prevention of prostitution* will never be, because the fault is radical in community life, and must prevail just so long as it is looked upon as a vice by one class of society and as an essential commodity by another.

If lessened morality is the price which all classes of society must pay for the abolition of prostitution, then the price is too high.

I do not believe that modern society or civilization is ready to prohibit prostitution. To control, to abate it, to ameliorate and qualify the conditions under which it exists—YES!

We can accomplish these things under municipal care by elevating the sphere of the social outcast to a higher plane through environmental provision and through municipal care, correlated with municipal control. In another paper,* I have ventured a suggestion as to educational provision in the form of homes, quietly conducted, which shall be always open to this class, to which they may come at any time, for rest, education or relief.

A prostitute is of exactly the same enforced morbid type as one sick with a distinct disease. The day has gone when victims of small pox, or other diseases are driven as a scourge out of a community, to die or to live according as their vitality keeps. In Siberia, it is true, the leper is fed by throwing his food to him, but Siberia is not civilized.

To-day every disease is treated with care and by improving surrounding conditions.

Other conditions of society, pauperism, crime, ignorance, are all being met and combatted, more with care than with brutal enforcement of generalizing community and statutory laws.

Prostitution is not a greater evil than some of these, and environmental conditions and influences can just as well ameliorate or CURE it as *they can produce it.*

APPENDIX.—*Comments upon the Conditions in New Orleans.*

"In New Orleans prostitution is limited to a special section of the city"—so reply both the mayor and chief of police to the Query 1 in the above list of questions.

In 1897, for the first time, a city ordinance was passed directed

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**Loc. cit.*

at the evil of prostitution. Its provisions directed that a certain section of the city, then occupied by this class of persons, be redeemed and a new territory, farther removed from the centre of the city, be set apart for the colony of women devoted to this life.

The immediate effect of this law was salutary. Almost all houses of prostitution in the proscribed district were vacated and the new district occupied. This condition lasted less than a year, when many of the vacated houses were reoccupied by the former tenants, while most of them were filled with a much lower class of prostitutes, of the kind who keep open doors and open windows, soliciting passers-by at all hours of the day or night. Up to the present writing, no attempt has been made to carry out the provisions of the ordinance, and the effect has been to more than double the size of the district occupied by the prostitute class.

Officially, there are 230 houses of prostitution and about 60 assignation houses. Officially, there are about 500 prostitutes, largely increased in winter, say by 500 more.

Houses are kept under strict police surveillance, quarterly reports are made by district officers of police to the superintendent of police; a written list of prostitutes, houses and assignation houses is kept at police headquarters.

The only laws existing, or previously existing, here have been directed at confining this class to special sections of the city.

Police regulations are directed at keeping houses orderly by compelling absence of noise after midnight; certain forms of dress (indicating occupation of the wearer) are prohibited, etc.

The laws are enforced only partially, but *in the judgment of the officials* they meet all requirements.

No provision is made for the examination of prostitutes.

[In 1891, the police authorities of New Orleans proposed that a city ordinance provide for compulsory medical examination of this class. The question was largely discussed, and promised to be brought to an issue. The women of New Orleans, however, held a mass meeting of indignant opposition, and this was the death knell of the movement.]

No register of prostitutes is kept, so no record of age, previous condition, etc., could be ascertained. The impressions of the city officials convey the opinion that a very small proportion of prostitutes here are minors. There is one institution in New Orleans for the reclamation of minors seduced and also with provisions for repentant fallen women. This is the "House of Good Shepherd," under the direct management ot the Sisters of Charity. Clandestine prostitution is recognized and houses of assignation are permitted.

No provision whatsoever is made for compulsory hospitalization of prostitutes diseased, and adequate provision for either male or female venereal cases is lacking at every institution in New Orleans.

The Charity Hospital, The New Orleans Polyclinic and Touro Infirmary provide outdoor clinics for the treatment of venereal cases, but the Charity Hospital has such meagre indoor provision that often cases are denied the indoor attention they fully need.

Until recently no especial statistics of venereal diseases were kept at the Charity Hospital; formerly these cases were grouped with skin diseases and were tabulated with them in the annual statements and catalogues.

None of the institutions referred to keep records of their out door venereal cases. Individual physicians on the visiting staffs preserve their own records, but the hospitals make no official entries beyond the age, occupation, and the fact that the patient is afflicted with a venereal disease.

The indoor service of the Charity Hospital provides more satisfactory data, as the diagnosis of each case is entered upon the records at the death or discharge of the patient, and this information is published in the annual catalogue.

Because of the absence of differentiation, however, in the annual reports, only suggestive statistics are to be had.

The tendency to-day is to more exact statistics on the part of the present medical staff of the Charity Hospital.

The following table will give some idea of the cases of syphilis (of all kinds) treated in the indoor service of Charity Hospital, and of the venereal diseases treated in the outdoor services for fifteen years past.

	Syphilis. In-Door Dept.	Syphilis and Veneral Diseases not Separated. Out-Door Dept.	Syphilis and Veneral Diseases not Separated. In-Door Dept.
1884	162	290	Not given
1885	131	299	1,101 venereal and skin
1886	157	289	1,168 venereal and skin
1887	126	263	614 venereal
1888	176	328	931 venereal
1889	206	339	859 venereal
1890	136	269	734 venereal
1891	133	259	734 venereal
1892	172	383	811 venereal
1893	230	482	2,616 venereal and skin
1894	292	588	2,644 venereal and skin
1895	469	692	2,485 venereal and skin
1896	210	407	1,567 venereal
1897	162	326	1,385 venereal
1898	200	381	1,187 venereal

The reports of the Touro Infirmary and the New Orleans Polyclinic do not separate these cases so as to afford statistic deductions. We have been unable to find any record of statistics as to the occurrence of syphilis or venereal diseases in prostitutes.

The police authorities acknowledge the presence of male prostitutes, meaning the class of sexual perverts who solicit. The number of these seems to be on the increase.

The present Superintendent of Police believes that the present regulations would control prostitution if they were strictly enforced. The impression to a cosmopolitan would bear out this statement; for, in no city of the size of New Orleans is there less evidence of prostitution to the casual observer. Besides the fact that a district is assigned to this traffic, custom has relegated the practice of venery to certain sections, and street walkers are far from numerous or ostentatiously offensive.

Another commentary of more than passing importance is the fact that of the applicants for treatment at the outdoor venereal clinic, by far the smallest class is among prostitutes, while in the female venereal ward (in the author's indoor service) of Charity Hospital, these women are exceptional. Not that venereal diseases do not flourish in New Orleans, but that most of these women have a degree of pride which sends them to the private offices of physicians whom they usually pay.

Syphilis in New Orleans, as in most of the cosmopolitan and metropolitan cities of the United States, is milder from year to year. The worst cases are among negroes, who are more neglectful than the whites, and who undoubtedly represent a more recent soil of infection.

Prostitution and venereal diseases in New Orleans both offer a field for study and for reform—from the standpoint of public health, if from no other.

CHLOASMA UTERINUM.*

BY EDWARD A. BLOUNT, M. D.

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It is chiefly of chloasma uterinum that I wish to speak, but so closely akin are all the chloasmata that it would be almost impossible to confine the discussion to this subject alone. It is wonderful how little has been hitherto written or said concerning these conditions; and none can realize this better than the general practitioner, for it is under his observation that the majority of the cases come even in this day of advanced specialism. It is a disease of private rather than of hospital practice, the proportion being seven to one in a number of cases enumerated by Dr. Bulkley, of New York. It may pass without notice in some of the more sensible subjects; but there are some semi-hysteric females, especially those high up in the social scale, who are driven to a state bordering upon insanity when that ruthless tyrant of their sex, uterine disorder, so fearlessly plants its ugly standard upon their foreheads and unfolds it to the public gaze. It is then that the family physician is called upon to confront one of the most difficult tasks of his professional existence, for these disfiguring spots of chloasma may at times prove very resistant to treatment. How disappointing it must be to him, then, to find that his heavy-tomed and handsomely illustrated work on dermatology, perhaps the latest acquisition to his library, dismisses the subject with a scant page and a half of heavy type; that the indices of his medical journals are barren of any mention of the subject; and that so great an authority as Dr. Jamieson is forced to admit that, "There are few elements of the skin about which we possess less precise information than about its pigment." These are my excuses for presenting the following lines on what may seem a trivial subject before a body of busy men engaged in general practice.

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*Read at Orleans Parish Medical Society, September 9, 1899.

Chloasma uterinum, from its color, presumably, has commonly been called "liver spot," and this misnomer has crept into all languages. "Chloasma" itself, which is the more correct term, is derived from a Greek word meaning "green," and at first referred to what is now known as pityriasis versicolor, an entirely different disease. Why it has outlived the words "melasma" and "xanthasma," which would much better have expressed the actual appearance of the disease, is only another one of the many curiosities of medical nomenclature.

Chloasma uterinum is commonly seen on the face—so commonly in fact that Gaucher, in his last admirable work, gives this as its exclusive location. Why such should be the case has never been satisfactorily explained, probably because it lies on the border line between dermatology and neurology, and directly within the province of neither. Since any pigmentation must be preceded by capillary dilatation and sanguinary stasis, one would naturally, in the absence of other conditions, expect chloasmata to appear below the knees rather than elsewhere. It is possible that such determining influences may be found in the fact that the vaso-motor system in the face is more highly organized and more sensitive to sympathetic influences than in other parts of the body, as is plainly evidenced by the quick blanchings and flushings of daily life. Whatever the explanation, however, the sites of predilection are undoubtedly the frontal, temporal and palpebral regions. Here the chloasma may sometimes appear as small disseminated spots, but is usually seen as a large patch passing across the forehead, sharply defined above, and fading insensibly into the normal skin below. There is always a distinct, narrow line of unaltered integument several millimeters in breadth separating the upper border from the roots of the hair. Not infrequently the spot extends in a horseshoe shape down on either temple. Cases have been reported where the whole face was covered with the exception of small islands of normal skin left here and there, which islands were, in one remarkable instance, at first mistaken for diseased spots, the rest of the surface being regarded as normal. Needless to say such pronounced cases are extremely rare. The color of the spots ranges from dark gray to black, but is nearly always some shade of brown. The degree of intensity of the coloring varies with heat, light and moisture, and with the plus or minus of blood in the affected parts, being, of course, more marked in the immediate neighborhood of any large vessels. The parts normally pigmented are the ones most apt to be affected. Thus, Kaposi mentions a woman who had a grayish wart on her face which became black each pregnancy, and was really her first warning of being in that condition. Chloasma always exhibits a tendency to return, and if a woman is a victim of it during her first pregnancy it is almost sure to recur during each succeeding pregnancy. Crocker cites one case in which the spots, at first scarcely distinguishable, became blacker each time.

There is absolutely no change in the skin aside from hyperpigmentation. Infiltration is never present, and in this respect more than in any other chloasma uterinum, which is of necessity purely symptomatic, differs from the idiopathic form of the disease which is seen usually as the result of pruriginous affections, and the ultimate type of which is found in "vagabond's disease," where the major portion of the skin may be thickened and darkly pigmented solely as the result of constant irritation. The spots of any symptomatic chloasma are smooth, without scales and perfectly on a level with the rest of the skin. Seborrhea may at times co-exist, but is by no means to be considered as a congeneric malady. Sensation is unaltered, and despite the statement of Cazenave, itching is hardly ever present.

Chloasma gravidarum is, after the first few months of pregnancy, always accompanied by an increase in the pigment of the breasts and abdomen which is at times quite extensive. Erasmus Wilson has seen almost the whole of the anterior surface of the body become of a negro blackness by full term. The formation of dark rings under the eyes of women suffering from painful menstruation is a kindred phenomenon, but is due more to simple nervous congestion than to an actual deposit of pigment.

This uterine chloasma, however, is by no means confined to pregnant women, any trouble of the genital organs may produce it. It is occasionally seen in unmarried women, but seldom before the age of thirty. Slight pigment changes do not always imply disease, being sometimes seen in perfect health. Chloasma is practically unknown before puberty, and almost invariably disappears with the menopause, the spots seen in the faces of very old women being due rather to the yellowing of the keratin through age. Like all chromopathic alterations, it is most common among mulattos. Among whites, anemic women are much more apt to be afflicted than full blooded ones. This fact is so noticeable that Erasmus Wilson gave it as a rule with few exceptions that, aside from racial differences, whenever an unwonted amount of pigment is met with in the skin, there is a deficiency of red blood corpuscles in the vascular system. This is why prolonged palludism, cancer, leprosy and other conditions that impoverish the blood, are also productive of chloasmata.

Chloasma uterinum is just as much a reflex secondary phenomenon as is the bronzing of the skin in Addison's disease. In each case the pigmentary change is due to irritation of the terminal branches of the sympathetic system;* and the only reason why the pigmentation is never extensive in the latter affection is found in the fact that the suprarenal capsules, which may or may not be destroyed, but are always affected in Addison's disease, are more intimately connected with the solar plexus than are the uterus and appendages, it being an undisputed fact that the cutaneous vascular system is peculiarly responsive to impulses coming from this plexus. For precisely the same reason utero-ovarian disorders are productive of more chloasmata than are cirrhosis of the liver, or constipation. No one can doubt that these chloasmata, however produced, are etiologically tropho-neuroses. So, in fact, is any pigmentary change, whether it consists in the manufacture and deposit of pigment *de novo*, as in chloasma uterinum, or in the total destruction of pigment, as in canities, or in the mere transference of pigment from one point to another, as in leucoderma. Whenever chromatosis is disturbed at all it is apt to take both directions, chloasma and complete achromia being often seen in the same individual.† Chloasma often follows a severe shock, and, if the truth were told in novels, the heroine's forehead would turn brown in a single night just as often as the hero's hair turns white. It may accompany any severe and continued nervous depression, and it is very common among the insane. The chloasma cachecticorum which follows the exhausting diseases, such as cancer, malaria, leprosy, etc., is due partly to diminished blood supply, but mostly to the fact that the vasoconstrictor nerves relax and the blood vessels lose their tonicity and thus permit the escape of red cells, each bearing its quota of pigment. Similarly is produced the peculiar mottled chloasma from arsenic, when long-continued exhibition of that drug has resulted in partial paralysis of the whole vaso-motor system.* In any case where the restraining tone of the vessel is lost there is a dilalation of arterioles and capillaries and consequent congestion, and wherever there is congestion there is apt to be pigmentation. This is notably demonstrated in the staining around varicose ulcers. The hematin escapes through the vessel wall, is converted into pigment, and, as long ago proved by Nothangel, carried by the migrating or "transport" cells † to the place of deposit, which is always in the rete mucosum. Congestion from local causes, such as vesicants and sinapisms, will produce the same result. Ziemsen notes a case where one mustard plaster but momentarily applied caused a deep discoloration that outlasted life. Chrysarobin is another fruitful source of such staining which is by no means confined to the site of application. Often indeed this point remains unstained although surrounded by a ring of pigment. Congestion is the cause of the artificial heat discoloration seen on the legs of stokers. No less an authority than Ziemsen induces a second etiologic factor in averring that it is the pigmentation produced by the sun's rays which, increasing through tens of thousands of ages, has blackened the skin of the negro races; and that the sun acts upon the skin not only by its caloric but by its actinic rays as well, the latter being possessed of some chemic power for the production of pigment. This theory seems partly borne out by the fact that when blacks are deprived of sunlight for any length of time, even though the same temperature be maintained, they are subject to various pigmentary changes, some of them becoming completely piebald. ‡

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* Guereau de Mussey, in *Revue Medicale*, February, 1879.

† E. Wilson, Diseases of the Skin, 1868.

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* Enriquéz and Lereboullet, *Lancet*, August 5, 1899.

† Unna, Histopathology of Diseases of the Skin, 1895.

‡ E. Wilson, *op. cit.*

Thus, also, may be explained the production of lentigines or ordinary cold freckles, despite the fact that the place where they occur is screened from the direct rays of the sun. Light, as well as heat, acting on the vaso-motor and trophic nervous system of the skin, produce an engorgement of the blood vessels which in turn results in the migration and subsequent concentration of pigment. Light and heat may act together or either may act alone.

These digressions into neighboring fields must be pardoned, since it shows us how closely allied are all the chloasmata so far as cause is concerned. It is seen clearly that it is to the slowing of the blood current from any cause whatever that we must ascribe the major etiologic role, and that any other can be but secondary.

As to diagnosis there is little to say. Chloasma could be confounded with only two other conditions. The first of these, pityriasis versicolor, is a parasitic disease, destroyed by sunlight, and, therefore, never seen upon the face, is itching, is somewhat hyperemic, is usually multiple, is scaly or easily made so by scratching, and spreads rapidly and by confluence. The second condition is the large pigmented macular syphilide upon which so much diagnostic stress is laid in the clinics of Paris and Vienna. These are usually confined to the posterior cervical region, however, and as a rule, either there is a specific history or evidences of actual syphilization. In Mexico, I once knew of a case being at first mistaken for the endemic *mal de pinto*, to the great discomfort of all concerned. As a rule, however, the diagnosis presents little difficulty, although it may at times become of great medico-legal importance in cases of supposed abortion.

In prognosis one should be extremely guarded and the patient should be warned that the outcome of any treatment, no matter how assiduous, is always a matter of doubt. Unless the exciting cause is first removed, treatment even the most skilful will probably yield only a temporary result, while by inexperienced hands matters are very apt to be made worse; and even after the removal of the cause by delivery, operation or therapy, chloasma may persist for months.

The treatment is of necessity almost entirely local, and to be successful must be vigorous. Since the pigment is actually deposited in the cells of the rete, the rational aim of any treatment must be to destroy these cells and to allow new ones to form devoid of pigment. Hence all the remedies employed are the so-called "epidermicides" or "discutients," such as strong acids, alkalies and other caustics. This method should be patiently followed, and too much should not be expected of it. One can not hope by the simple exfoliation of the superficial cells of the rete to cure every case of pigmentation, or to thus remove the metallic silver of argyria, or the metallic iron of siderosis, or the gunpowder blue and cinnabar red of tatooing, or the deeply imbedded bile pigments of icterus; but one may, with the utmost confidence, prognose and accomplish a cure in almost any case of secondary, symptomatic, or true chloasma. One must remember, however, that if too great and too long an irritation is produced, the only result will be an augmentation of the existing pigmentation. The most widely employed and highly recommended remedy the world over is corrosive sublimate. For a delicate skin a grain to the ounce solution, frequently applied, is strong enough and may produce wonderful results; but, if the chloasma persists, resort must be had to Hebra's severer form of treatment. He dissolves five grains of sublimate in an ounce of alcohol or distilled water and applies this constantly to the spots by means of compresses for at least four hours. A blister forms, which must be pricked and then dressed with powdered starch or other inert powder. The epidermis falls off in from three to five days and new unpigmented skin is usually left. Salicylic acid is highly recommended, and, used either as a paste or a plaster, is very effective. Hydrogen peroxide, benzoin, veratrin and other drugs too numerous to mention are of service in mild cases. They all operate in the same way as the bichloride compress described above, and the only difference lies in the intensity and extent of their epidermicidal action.

Personally, I have gotten my best results after the use of the following combination:

℞	Hydrargyri bichloridi	gr. viii.
	Acidi acetici dilut.	ʒiii.
	Sodii biboratis	℈ii.
	Aquae Rosae, q. s. ad	℥iv.

Apply on compresses every three hours.

Pages might be filled with prescriptions, but that would be but an insult to the reasoning powers of the reader. One very important point to be borne in mind, however, is that great care must be taken to remove any hysteric condition of the mind, since hysteria may indefinitely prolong the cure. Tell the woman that the oftener she looks at herself in her mirror, and the longer she dwells upon her ills in conversation with her garrulous neighbors, the greater will be the duration of her malady. If despondency is a prominent feature, we always have at hand an unfailing nerve stimulant in strychnin; while if hyperexcitability is noticeable, the bromides suggest themselves. By far the best nerve tonic in hysteric cases is the compound sumbul pill as suggested by Goodell and prepared by Warner. It is impossible to overestimate the importance of rearranging the nervous equation. Just as an electric alarm may continue ringing, though the hand that pushed the button has been removed, provided the mechanism be deranged, so may the signal of visceral disorder remain upon the face long after the viscus has resumed its wonted function, if there but be a flaw in the intricate network of nerves that has flashed the signal to the surface. Among other things, then, be sure that the circuit is complete.

Clinical Report.

FOUR CASES OF FIBROIDS OF THE UTERUS TREATED WITH THYROID EXTRACT.*

By C. JEFF MILLER, M. D., Clinical Instructor, New Orleans Polyclinic, etc., New Orleans,

During the past five months I have administered the extract of thyroid gland to four women in whom fibroids of the uterus were present, and the results were such that I desire to place the cases on record. Just at present when glandular extracts are being administered so promiscuously for various diseases I feel it the duty of every one to report their observations in order that a final consideration of the subject may be made possible. The reports of the effects of glandular extracts are particularly important. No method of treatment has been so empirically applied nor given such varied results. These four women had either refused operative interference or were in such a physical condition that any radical procedure would have been extremely hazardous. In each instance the most annoying and serious symptom was hemorrhage, the next in importance and frequency was pain. All other therapeutic agents were discarded in order that a fair trial of the thyroid extract could be given. The preparation of gland used in each instance was the tablet form, administered in doses of one to five grains three times a day, the amount varying according to the effect produced.

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*Read at Orleans Parish Medical Society, October 14, 1899.

Three of the women were colored, and two of them were treated in the gynecologic clinic at Charity Hospital. The first case, a colored woman, 40 years of age, came in June, 1899, giving a history of menorrhagia for sixteen months. During the last three months before consulting me, menorrhagia had existed, and her weight had been reduced from 155 to 130 pounds. She was extremely anemic and weak and complained of almost constant pain and tenderness in the lower abdomen and sacral region. She had noticed the presence of a small hard tumor in the lower abdomen for three years, but it gave rise to no discomfort for nearly eighteen months, during which time it increased considerably in size and could be noticed by simple inspection of the abdomen. She was the mother of three children, the youngest being 14 years of age. Examination revealed the presence of a multi-nodular fibroid of the uterus which extended upward to one inch above the umbilicus; below, it completely filled the pelvis and involved the lower segment of the uterus and cervix. The cavity of the uterus was four and one-half inches in length. She was willing to undergo an operation, but besides her general depression and anemia, albuminuria was present, and I advised against her entering the hospital until she was improved. Thyroid tablets of five grains each were given, and she was directed to report any unpleasant symptom. For a week some very annoying symptoms prevailed. Tachycardia, extreme nervousness, warm flashes, were pronounced, and only disappeared when the dose was reduced one-half. The dose was again gradually increased to fifteen grains daily and gave no more trouble. In two weeks the metrorrhagia ceased, and the second period after the institution of treatment was normal in amount and length of flow. The menses since then are normal, the pain has almost entirely disappeared and the tumor has receded below the umbilicus and shows a general shrinkage of about one-fourth. Her general health has improved, she has increased ten pounds in weight and albuminuria is only noted occasionally. The tablets do not seem to give any inconvenience, and she is taking them regularly.

Case II. A colored woman 37 years of age, first seen in gynecologic clinic of Charity Hospital. Was the mother of one child 12 years of age. She sought relief from profuse and painful menstruation of twelve month's duration. An examination revealed the presence of a fibroid of the uterus about the size of an infant's head. Operation was declined. The administration of thyroid extract was commenced in two grain doses three times a day. In her case it proved to be a marked cardiac depressant and produced extreme nervousness and headache. It was continued, however, the dose being varied according to the effect produced for two and one-half months without the slightest effects upon hemorrhage, pain or the dimensions of the tumor. During this time a heart murmur which was hardly audible when I first examined her, became quite noticeable. I could hardly attribute the change to the thyroid, however.

Case III. Mrs. A., white, 39 years of age and mother of one child 16 years old, had known of the existence of a tumor in her abdomen for eight years. For five years she had been subject to menorrhagia, and occasionally attacks of metrorrhagia occurred which on three occasions was so serious that packing of the uterine cavity and vagina was necessary to control the hemorrhage. The cavity of the uterus was five inches in length. The fibroid involved the whole uterus and extended as high as the umbillicus. She declined operative intervention, and was advised to take thyroid extract. It was administered in five grain doses (20 grains a day) for two months without appreciable effect upon the hemorrhage or pain. No systemic effect was noticed, excepting an occasional severe headache.

Case IV. A colored woman, 40 years of age, came to the gynecologic clinic giving a history of profuse menstruation and occasional attack of excruciating pain. The menses usually lasted twelve days and left her quite weak and anemic. She had known of the presence of a tumor in her abdomen for five years, which according to her statement, had increased rapidly during the past fourteen months. The tumor was a multi-nodular fibroid, involving the whole uterus (interstitial type), was pressed firmly down into the pelvis and almost immovable. It extended upward to the level of the umbilicus. She was admitted to the gynecologic ward for operation, but an examination of the urine revealed quite an amount of albumin and the operation was deferred. She returned to the clinic and extract of thyroid was prescribed. This was continued in five grain doses three times a day for the past three months. She menstruated two weeks after the treatment was commenced. The flow only lasted five days and was not profuse. The pain which had been so severe as to confine her to bed for three or four days each month, was markedly relieved. There has also been slight diminution in the size of the tumor, though not so much as in case No. 1.

In two cases the results were quite beneficial; the others showed no improvement.

Clinical Lectures.

[Specially Reported for the JOURNAL from the Philadelphia Clinics.]

I. A CASE OF APHASIA IN TYPHOID FEVER IN WHICH THE CAUSE IS DOUBTFUL. II. EARLY PNEUMONIA IN TYPHOID FEVER, ITS PROGNOSIS AND TREATMENT.

By PROF. J. M. DACOSTA, M. D.

I.

All sorts of complications in typhoid fever have been seen during the present epidemic, but the one I now show is a rare one, and because of certain conditions is exceedingly interesting. The case is that of a girl who, seven days before admission to the hospital, began to show the ordinary symptoms of typhoid fever. The disease ran its usual course, spots appearing four days after admission, and at the same time what is known as a subcuticular blush made its appearance. This, however, is not out of ordinary, and the case was not looked upon as being in any way an unusual one.

The patient remained in this condition until the seventh day after admission, when the condition now present came on suddenly. She understands everything perfectly, but has marked aphasia. This came on four days ago and has persisted since except for a few minutes yesterday morning when she was able to talk quite well. The case was studied from a clinical point of view by testing different parts of the body as to their involvement in the process. This showed that there was no motor or sensory disturbance in the extremities, and no difference whatever in the condition of the two sides could be detected. Although the condition of the patient is such as to make the examination less satisfactory and positive than if she could talk, I believe that there is no involvement whatever of the body. She can move her tongue, lips and face perfectly well; hence there is no mechanical difficulty or local paralysis causing loss of speech.

Let us notice a couple of points in regard to the case before trying to determine the cause of this condition present. First, the girl is unusually quick in her mental processes for a person who is suffering from typhoid fever. As noticed from her expression she understands everything said about her with a quick intelligence that is seldom seem in this disease. Second, no phenomena of hysteria have been observed in the patient previous to her attack, she not being even what would be called a nervous person. With these considerations, let us study the case.

Aphasia unconnected with paralysis is extremely rare in typhoid fever. This condition is generally associated with a right-sided hemiplegia, and is due to a thrombosis of a vessel in the anterior convolution of the brain. Again, aphasia in typhoid fever is noticed oftener in children than in adults. But there is clearly no thrombosis in this case, there being no cerebral symptoms whatever. There are, however, two other explanations of this condition, although after analyzing them, there is an element of doubt as to which may be the cause in this instance of remarkable loss of words. First, we may have the poison of typhoid fever, the bacilli and their toxins, affecting the nerve centre. This is just as we have the poison of diphtheria, for instance, acting on the system and causing various paralyses. We may well conceive then that the typhoid bacillus may act on portions of the brain in the same way. This is a possible and plausible theory. Second, it may be that this poison of typhoid fever has so affected the nervous system that it has caused a hysteric symptom of loss of speech. This is as reasonable as the occurrence of hysteric palsy in the extremities, and various palsies resulting from fright. Here then may be a localized hysteria. It is by no means easy to say which of these two causes are acting in this particular case. If I were asked what I *think* of the matter I should say that the latter is the more probable explanation in my opinion. What inclines me to this view is the fact previously mentioned, that a day ago the patient had the use of speech for a few minutes. This seems rather to denote hysteria than the local effect of poisons on the speech center. However, this is a matter of speculation. The fact is that there is no organic change in the brain or the patient's intelligence would not be so good, and she would not have recovered the use of speech for the short time mentioned, hence her chances for recovery are good.

How shall we treat the case in order to favor this recovery as much as possible? Obviously the general and nervous systems should be strengthened as much as possible. The patient has been getting the usual typhoid treatment, betanaphthol, stimulants, and strychnin. She sleeps well, and the question is whether anything should be added to the treatment. There is no hysteria in the history, unless this be such at the present time. It might seem that no other treatment were necessary to quiet the nerves, yet I think the girl would be better if a little sedative were administered. So we shall give her one two-hundredth of a grain of hyoscin hydrobromate daily. Strychnin will be given to the amount of one-fortieth of a grain every eight hours. I think she should also receive rather more nourishment than is given ordinary fever cases. She is getting three pints of milk and one of broth daily. To that will be added a wineglassful of the extract of malt three times a day, also, as aiding the nutrition of the brain, a teaspoonful of the syrup of hypophosphites three times daily.

This case not only illustrates one of the rarer complications of typhoid fever, but also furnishes food for reflection. It shows the possibility of the brain being influenced by typhoid poisons or hysteria of the system caused by the same toxins. It helps to illustrate the many and various manifestations of nervous symptoms of typhoid fever.

II.

The case in question is that of a negro girl of eleven. She has a true broncho-pneumonia of the left lung, one peculiarity of which is that it came on early in the course of the fever at about the ninth day of the attack.

As to the prognosis in these cases it may be said that the presence af pneumonia is a grave complication, the variety in question being less grave than is croupous pneumonia. As a general rule the earlier in the course of the fever it occurs the worse prognosis. Does absolute recovery take place in these cases that seem to terminate favorably? That depends. In pessons who have a tendency to tuberculosis the consequences are apt to be grave, as there is a peculiar liability to the beginning of this disease in such patients.

The treatment in this case has been three grains of betanaphthol every four hours, and whisky, one-half ounce every three hours. The patient has also been sponged with alcohol at 103 deg. In addition she has been given five grains of the carbonate of ammonium every fourth hour for the relief of the lung condition.

Two Cases of Chronic Lead Poisoning with Treatment of Each.

BY PROF. ARTHUR V. MEIGS. M. D.

Our first case is that of a Russian, who came to the hospital with the history of having worked six weeks in a lead works. His work was moving lead powder and dumping it, the dust which arose being inhaled. The blue line on the gums is distinct, and his principal complaint has been that of violent pains in the abdomen.

The four forms of chronic lead poisoning generally given, in their order of frequency, are lead colic, arthralgia, paralysis and encephalopathia. This is especially the classification of French writers, but in this country, at least in my experience, arthralgia is a rare form. The order in which I place them is colic, paralysis, encephalopathia and arthralgia.

As to the treatment, three indications are set forth in books and in the following order of importance:

First, eliminate the lead from the system; second, get the bowels of the patient open; third, relieve the pain. This applies to the treatment of colic, which is the condition of this man. But this is just the order that should not be followed. The first thing to do is to relieve the pain and let the others wait. There is no great hurry about them, and in my experience, the bowels cannot be opened until the pain is relieved anyway.

Even if they should be opened the pain won't be relieved for a certain time, and there is no use of giving the patient purges which do no good, but only add to discomfort. The pain cannot be stopped at once, but generally can be in two or three days. But there is no great difference if the bowels be closed for a week, so long as there is no obstruction. Relieving the pain, then, is the best thing to be done toward bettering the patient's condition, to say nothing about the increased comfort afforded, which is no small item.

We gave to this man one-fourth grain of powdered opium and one-twelfth of a grain of the extract of belladonna every two hours. The pain was relieved in about two days. If this is not sufficient in such cases ten drops of laudanum can be given twice at night in addition, or a one-grain opium suppository. After this man's pain was relieved we gave him one-half ounce of Epsom salts night and morning until the bowels were opened. Third and lastly he was given iodide of potash to eliminate the poison from the system. From five to ten-grain doses three times a day is sufficient.

In regard to the use of opium, as I have frequently said, one-quarter of a grain of the powdered drug or ten drops of laudanum can be given every two hours day and night for a week or two without making the patient stupid or sleepy, or contracting the pupils.

If more than this be given the patient must be watched very closely. The steady use of opium, as I have indicated, is much better in these cases than is the hypodermic use of morphin. The pain cannot be relieved at once, but must be done gradually, hence the opium is better.

The second case which I present was rather an obscure one and is yet, to some extent. The man is an Italian, a tailor by occupation. Three months ago he began having stomach trouble. He vomited at times after meals, this being accompanied by pain. A few times blood was noticed in the stools. His hands and feet are cold. His pulse is very feeble, hardly to be felt and the heart is irregular. There is no murmur, and no evidence of lung disease. The doctor who sent the man here thought he was suffering from some form of gastralgia. The case was puzzling, but remembering the man was a tailor, I looked in his mouth and thought I detected a faint suspicion of a blue line on the gums. Further examination revealed a distinct blue line on the buccal mucous membrane extending backward along the junction of the upper and lower teeth. An examination of the urine since shows the presence of lead, but is otherwise normal. The man has not complained of pain, but only the persistent vomiting. There is no doubt of the lead poisoning being present, but we might be led into error if we treated him only for it. But we do not know if there is a complication present or not, the man's heart is so rapid and feeble that he may die. His voice is weaker than it was yesterday, which may be due to the excessive vomiting he has had for some time.

The things to be done in this case were to stop the vomiting and, what was really more important, to get food to stay in the man's stomach, as he was practically in a state of starvation. Two ounces of milk, one-half ounce of limewater and two drachms of brandy were given every two hours. Another important point in the treatment was the giving of one twenty-fourth of a grain of morphin and one minim of chloroform in a drachm of the compound tincture of cardamon every two hours, fifteen minutes after the food was given. The patient has not vomited since this treatment was begun, but whether he is distinctly better is hard to say. I rather think he will not recover, but whether his present condition is due to some underlying condition, or is a faint change for the better, we can not tell. Digitalis had been given before I saw him, but I stopped this because I thought it more important to relieve the vomiting first, and did not wish to have the digitalis interfere with this. Heart stimulants will be given as soon as the vomiting is really stopped. The chloroform given as mentioned is warming and sustaining to the stomach, and this prescription will be found very useful in the vomiting of cholera morbus, etc.

In regard to giving food in cases of vomiting the patient had better be left alone for twenty-four hours if the attack comes on suddenly in a comparatively well-nourished individual. The stomach and patient both will generally rebel and they are just as well off if neither food nor medicine be given, unless, perhaps, some trifling drug in certain cases. But if the vomiting is long continued I think it is a mistake if food is not given. This should be done even if the vomiting still persists. I have seen cases of cancer of the stomach where vomiting occurred oftener than every two hours, yet, if milk were given, about two ounces at a time, and vomiting occurred twenty minutes after no trace of milk could be found in the material ejected. Something must have become of it, and I am certain that nature retains what she needs in such cases and rejects the mucous and other matter not needed. So I think it is a mistake to withhold food in such cases; even if the most of the food should be vomited, the patient will vomit anyway, and if there is something in the stomach this is rendered easier.

Only in the most exceptional cases would I keep from giving food, as a patient can not live for a great length of time on nutritive enemeta. This will be for a few days, but will not answer well for long periods. This, I know, is a matter of opinion and can not be demonstrated by any exact proof, but I firmly believe a mistake is made if food is stopped because of vomiting in long continued cases.

N. O. Medical and Surgical Journal.

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

CHRISTMAS.

"We ring the bells and we raise the strain,
We hang up garlands everywhere
And bid the tapers twinkle fair,
And feast and frolic—and then we go
Back to the same old lives again."
—*Coolidge.*

ORGANIZATION.

Medical men have met the demand of progress by everywhere establishing local, general and national associations for the study of every branch of science relating to the field of medicine.

These associations have broadened their usefulness as the years have gone by, until to-day they represent the forums of medical advance.

This work has gone on, gradually growing in strength and importance until the broader education resulting has brought with it some reflected good to the public at large.

Legislation in certain fields of preventive medicine; the improvements in the municipal care of the sick; the better care of the insane; the broader recognition of medical science at the hands of the intelligent public; all these have directly or indirectly followed the liberal interchange of thought and opinion among those who constitute the backbone of medical association working.

The present legislative acts in some States directed at regulating the practice of medicine have been brought about by the persistent discussion of their necessity.

At about this point, the medical profession has stopped, waiting, perhaps, for another evolutionary move to carry them to a higher point in the scale of progress.

We have before now sounded the note of warning with regard to the parasites on the profession; we have striven to arouse the rank and file from the lethargic state in which they have lived, burdening themselves with the opprobrium of neglect of self-interest. We have remarked the encroachments of the druggist upon the physician's prerogatives, but the words have borne small fruit.

Each day brings its lesson of wisdom and the growing evils of the patent medicine concern, finding easy field for advertisements in the lay press, together with the evident tedious delay in the prosecution of quacks forcibly brings the question home,—How can these things be stopped? We have waited and watched and the answer seems to us direct, by organization!

In London, there exists a "Medical Defence Union," whose purpose is to protect the practitioners of medicine. Why not create such an institution in this country?

With small dues and large membership, such an organization would soon be able to place itself upon a basis demanding respect, moral and physical as well as legal.

The occasional punishment of some stray offender, while the gross offences are passed by, would soon be replaced by a vigorous system of protection by prosecution as well as defence.

The medical profession needs to be rid of the numerous infringements on their rights, and since those qualified and authorized to enforce the law are now either timid or prevented, we should have another way, free from politics and free of everything excepting might and right.

SUBSTITUTION BY THE DRUGGIST.

We read in a recent issue of the Chicago *Times-Herald* of a decision of considerable importance made by Judge Kohlsaat in the United States District Court. In a bill for an injunction, Fairchild Brothers & Foster, of New York, had charged a Chicago druggist with substituting a spurious and inferior preparation for "Fairchild's Essence of Pepsin" in several cases where the latter was expressly called for in physicians' prescriptions. The judge sustains the charges made, perpetually enjoins the druggist from ever repeating the offence and taxes him with the costs. Judge Kohlsaat's decision will probably protect manufacturing chemists, physicians and the general public, all of whom have in the past suffered from these fraudulent practices of a certain class of druggists.

The justice of the decision should be clear to every one. The patient has the right to get what he calls for; the manufacturer should not be discriminated against by an individual who desires dishonestly to increase his profits; but, especially, and that is where we are chiefly concerned, the physician's order must be respected. After all, a prescription is nothing but a direction to the pharmacist to prepare or compound a certain thing or things. The physician may leave the quality of any given ingredient to the discretion or honesty of the drug man, but if, in the doctor's judgment, it is proper or wise to demand an article of special quality or manufacture, it is just as wrong for the druggist, without permission, to substitute that of another quality or manufacture as to give another ingredient which he considers "just as good."

It is a comfort to realize that the honest pharmacist also is protected by the decision referred to, inasmuch as it will diminish the chances of his unscrupulous rival resorting in the future to substitution in order to boost an unfair competition.

All honest people should rejoice at the decision, druggist as much as doctor, patient as much as manufacturer.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

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ANESTHESIA RESULTING FROM COCAINIZING OF THE SPINAL MARROW.—Seldowitsch, of St. Petersburg, in *Centrbl. für Chir.*, No. 41, gives the results of his investigations on animals and of his experience in man. As his report on the investigations upon animals is to appear shortly in one of the Russian medical yearbooks, his paper now referred to relates only to the results in the human being. He takes occasion to remark, however, that the phenomena in animals agree with those observed in man.

The following cases are reported:

Case I.—Female, aged 59, cancer of the foot.

May 11, two syringes of ½ per cent. cocain solution were injected between the third and fourth lumbar vertebrae; loss of sensibility came on 8 minutes later, and extended to the ant. sup. spine of the ilium, the sensibility being from here up to the costal arch only more or less diminished.

Operation: Pirogoff's osteoplastic amputation of the foot; duration, 40 minutes; absolutely painless, the patient remaining quiet on the table and amusing herself with the bystanders.

Sensation returned 56 minutes after the injection of the cocain.

Five and a half hours after the operation there were sensations of chilliness and vomiting; the temperature, which before the operation was 36.6 deg. centigrade, rose toward evening to 38.9 deg.; pulse 100, patient excited.

May 12, temperature 38.6 deg.; cephalalgia and slight qualmishness.

May 13, temperature 37.4 deg. in the morning; 37.3 deg. in the evening; no headache, no vomiting, general conditions gratifying.

The further course was quite normal. The wound healed per primam, and the patient left the hospital feeling in her normal condition.

Case II.—Female 50 years of age. Extensive melanosarcoma of the calcaneum; metastases in the femoral and inguinal glands. The patient was reduced greatly by continuous bleeding from the tumor.

May 20, injection of 0.006 cocain; complete anesthesia after nine minutes. Operation: Amputation of the leg and extirpation of the glands, total duration of the operation thirty minutes. At the conclusion of the operation as the skin stitches were being placed in the inguinal region the patient began to complain somewhat of pain. The sawing of the bone was done without any pain whatsoever.

The temperature, 36.8 deg. before the operation, rose four and a half hours later to 38.7 deg.; two hours later was 39.2 deg.; two hours later was 38.6 deg., and in two hours more 38.2 deg. Towards evening patient had chilliness, cephalalgia, dizziness, dryness in the mouth and was excited.

May 21, temperature 36.9 deg. morning, 37.0 deg. evening. General condition good. The patient, who had at first fairly well recovered, went down five weeks after the operation from increasing cachexia.

At the autopsy nothing abnormal was disclosed either in the spinal canal or in the cord.

Case III.—Female 55 years of age, extensive carcinoma of the skin on the outer side of the right leg in the region of the knee. This had developed out of a burn—scar of childhood. The inguinal glands were enlarged.

May 26, injection of two syringefuls (with two minute interval) of ½ per cent. cocain solution (0.01 cocain). The anesthesia began in five minutes. The glands were first removed and the wound sutured; the cancer was then extirpated, both operations being done under complete anesthesia. The large defect at the right knee was closed by Thiersch grafts from the left thigh, the cutting of the grafts being somewhat painful.

The anesthesia lasted 35 minutes and extended to the navel, the sensation from here up being only more or less diminished.

The operation was finished at 11:15 A. M. In the course of the day there were headache and dizziness, pulse 90. At 2 P. M., a chill.

Temperature before the operation, 36.8 deg.; 1 P. M., 37.4 deg.; 3 P. M., 39.2 deg.; 4 P. M., 39.9 deg.; 5 P. M., 39.6 deg.; 6 P. M. 39 deg.; 7 P. M., 38.6 deg.; 9 P. M., 37.8 deg.; 11 P. M., 37.5 deg.; 2 A. M., 37.7 deg.

May 27, temperature morning, 36.8 deg.; evening, 36.9 deg.; vomiting, headache and dizziness.

May 28, temperature normal, headache and qualmishness.

These phenomena disappeared next day and the further course was normal. The transplanted skin adhered, the wound in the inguinal region healed per priman and the patient left the hospital completely well.

Case IV.—A girl of thirteen years. Tuberculosis of the right knee joint, ankylosis at an acute angle, right sided skoliosis.

July 25, injection of a syringeful of 1 per cent. cocain solution (0.009 cocain).

Operation, total knee joint resection. Beginning of the anesthesia nine minutes after the injection. In the beginning she was excited, but soon became quiet, even the sawing of the bone ends being absolutely painless. Duration of operation, 50 minutes; applying the skin stitches was likewise painless. The behavior of the patellar tendon reflex was in this case as in all the others, normal.

Operation ended at 11:30 A. M.; at 1, a chill of short duration; at 2 P. M., the temperature mounted to 39.0 deg,; at 3 P. M., it was 40 deg.; at 5, 39.5 deg.; at 7, 39.9 deg.; at 8, 39.4 deg.; at 9, 39.2 deg.; at 11, 39 deg.; at 1:30 A. M., 38.5 deg.; at 4 A. M., 38.2 deg.

July 26, temperature morning, 36.5 deg.; general feeling progressively good, neither headache, dizziness nor vomiting; pulse 130, pupils dilated.

The further course was normal, temperature normal and absence of any uncomfortable sensations whatsoever.

The pupil dilatation disappeared after a few days. The wound healed per primam and the patient feels at present well.

The author is of opinion that the almost invariable rise of temperature, the headache, the dizziness, the vomiting, the dryness of mouth and the chill are, contrary to the views of Professor Bier, to be ascribed to the toxic action of the cocain itself. Injections of the same amounts of salt solution had no such effect, nor can it be attributed to the loss of cerebro spinal fluid, since none escaped in any case here reported. It is to be hoped that further investigation show us how to use these injections effectively without the disagreeable phenomena heretofore noted.

GUN-SHOT WOUND OF THE BRAIN, WITH PERFORATION OF THE PALATINE ARCH. LOCALIZING THE BULLET IN THE CORPUS CALLOSUM BY MEANS OF THE X RAYS. EXTRACTION OF BULLET.—RECOVERY.—Mr. Barker, of London (*Revue de Chirurgie*, October, 1899), relates the case of a man who shot himself twice in the mouth with a revolver of 7 *m. m.* caliber. Only on the 18th day vomiting began with paresis of the left side and congested pupil. The Röntgen rays revealed the two projectiles, one located in the sphenoidal body, the other on the corpus callosum 4 cent. from the vertex, midway between the root of the nose and the external occipital protuberance.

Spontaneous improvement. But on the night of the 66th day, the patient, after retiring, had a pronounced epileptic attack, with loss of consciousness and rise of temperature.

Recurrence of similar attacks on following days. Immediate intervention. A quadrangular osteo-cutaneous flap was made on the right parietal bone. Incision of the dura-mater. with the little finger along the falx cerebri, to a depth of 2½ cent., the bullet was easily seized and extracted. Suture of the dura-mater. Union by first intention.

Immediately after the operation, complete left hemiplegia set in, disappearing in a few days. Three months after the patient began to walk.

RECURRENCE OF TRIFACIAL NEURALGIA, CAUSED BY NERVE REGENERATION AFTER EXTIRPATION OF THE GASSERIAN GANGLION.—Garre, of Rostock (*Revue de Chirurgie*, October, 1899), narrates a case of facial neuralgia, in which, after resection of the third branch at the base of the skull, he was, on account of recurrence, obliged to resect the gasserian ganglion. At the end of the third year, pain reappeared in the region of the superior and inferior maxillary nerves; the previously resected nerve trunks were looked for and found to be regenerated, and formed by normal nerve fibres, without a sign of degeneration.

Department of Obstetrics and Gynecology.

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AFTER-RESULTS OF OPERATIONS FOR REMOVAL OF UTERUS AND APPENDAGES.—*The British Medical Journal* (October 28, 1899) presents a lengthy extract of an article read before the British Gynecological Society, by J. Furneaux Jordan, on this subject, based upon forty-three cases of removal of both appendages for disease, and twenty-four operations for myoma of the uterus. The following points were investigated: The severity and duration of the symptoms due to the production of the menopause, and their occurrence at fixed periods. 2. The continuation of menstruation after operation and the occurrence of vicarious menstruation; the effect of the operation upon the body weight, the effect upon the marital functions, the condition of the abdominal scar, the state of the general health and the capacity for work.

He was led to the following conclusions.

The final result of removal of the appendages for inflammatory diseases is uniformly good; the severity of the artificial menopause is most marked in young women; the mortality in severe cases of pyosalpinx treated by abdominal section is higher than one would wish; the use of the drainage tube involves a weak spot in the scar; the likelihood of leaving behind some portion of ovarian tissue is great in cases of very dense adhesions; the effect of this passes off in time. If the appendages are entirely removed, menstruation ceases immediately.

Mr. Jordan says: Be as conservative as possible, especially in the case of young women; treat the severe cases of pyosalpinx if possible by the vaginal route; do not drain unless absolutely obliged to, and thus consider the possibility of draining by the vagina; do not get disheartened if the patient does not get the full benefit of the operation for some little time. He found that the sufferings of the artificial menopause, when the appendages were removed for myoma, were much less, on the whole, than in cases of removal of the appendages for disease. The menopause following hysterectomy was less severe than in cases of removal of the appendages, but the average age of the patients at the time of operation was greater than that of the patients who underwent the operation of removal of appendage, for disease. As regards the general health of the patient after operation, on the whole the final results were very good.

GONORRHEAL INFECTION DURING THE PUERPERIUM.—Cumston states that as far as we can ascertain, all authorities agree that gonorrheal infection during the puerperium runs a milder course than other septic processes arising during the lying-in period.

The milder course of the symptoms and their rapid subsidence in puerperal gonorrhea by no means indicate that the process has been cured, and it is a well established fact that the gonorrheal puerperium is extremely chronic and defies treatment, just as is the case with gonorrheal processes in the female in general. This is especially true of recurrent perimetritis as described by Noeggerath.—*Am. Journal Obstetrics*, October, 1899.

THE INFLUENCE OF THE POSITION OF THE WOMAN ON THE FORM AND DIMENSIONS OF THE PELVIS.—Dr. G. Walcher presented an elaborate paper on this subject at the recent meeting of the International Congress of Gynecology and Obstetrics. As to the practical side of the question the following conclusions were reached:

In moderately contracted pelves there will be scarcely any reason for using the position with hanging thighs, especially when there is a head presentation and where the uterine contractions are regular. When the woman is allowed to choose for herself the most convenient position she will place her thighs in the most favorable position for the enlargement of the pelvis. When the contractions are insufficient and the head does not enter the brim the woman may be placed now and then in the position with hanging thighs, and in the same time the head may be pressed into the pelvis according to Hofmeier's suggestion.

Above all things it is in obstetric operations and particularly in applications of the forceps, the head not having passed the brim, and in extraction after podalic version that the supine position is useful.

When the head has not wholly entered the cavity, the woman being in the position with hanging thighs, the femora must be elevated again, whilst traction on the head is continued, to displace the anterior part of the pelvis upward. Once the head being in the excavation the extraction ought to be finished in the obstetrical position.—*American Gynecological and Obstetrical Journal.*

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Treatment of Chlorosis and Anemia.—It is not simply iron, but it is the administration of a suitable preparation of iron, together with a proper regulation of the patient's mode of life and the intelligent choice of measures for the relief of the disturbed functions. When fatigue has been a contributory agent, rest in bed is imperative. Removal to a different environment, stimulation of the skin by bathing, and the establishment of a better circulation by friction and massage are of great assistance. Some degree of dyspepsia exists in the majority of chlorotics, and often this must be relieved before iron will be efficacious, or perhaps even be tolerated. Lavage produces better results in the improvement of digestion than were obtained by drugs. Yet the latter are indicated: Simple bitters or strychnin before meals, hydrochloric acid if secretion is deficient, or full doses of alkalies if hyperacidity exists; bismuth salicylate to check abnormal fermentation; naphtol or chloroform water three to four hours after meals in cases of dilatation. As regards iron, the favorite forms of giving it are as Blaud's mass, sulphate of iron in Startin's mixture (Clark's), lactate of iron (Quincke), Liq. ferri sesquichlorid G. P. (Israel), tinct. ferri chloridi (Nothnagel), protoxalate of iron (Hayem). The best guide to the choice of a preparation of iron is the condition of the stomach. In many cases, betanaphtol, grains 2, with Blaud's mass, grains 5, thrice daily, or salol and hydronaphtol in 5-grain doses with iron, securing intestinal antisepsis rapidly increase the hemoglobin.

Relief of the associated constipation of chlorosis, and of that which is induced by many of the iron preparations is also imperative. For that purpose, cascara is often better tolerated by the stomach than the salines. Strychnin is of service for its general tonic effect upon the stomach and upon the circulatory and nervous systems. In a similar manner digitalis, by slowing and steadying the cardiac action, will add to the patient's feeling of well being.

There is a general consensus of opinion that treatment should not be abandoned when the subjective symptons are relieved, but to avoid relapse should be persisted in until the hemoglobin reaches or approximates the normal.—Southworth, *Medical News*, October 14, 1899.

Transmission of Malaria.—There is now positive experimental proof that two mosquitoes—*anopheles claviger* and the *anopheles pictus*—are capable of conveying estivo-autumnal fever to man, the former apparently more commonly than the latter. It is also just as firmly established that the anopheles claviger is the conveyor of tertian infection. It has been further shown that the infection can be conveyed by the mosquito to man, and from man back to the mosquito, thus completing the cycle of development and firmly establishing the mosquito theory.

The mosquito theory having been definitely established, it is only natural that some one should come forward and suggest some practical method for the extermination of the mosquitoes which convey the infection, and thus to wipe out the disease at least in certain localities. Ross, who first gave the mosquito theory a firm foundation by his experimental work, also has the honor of being the first to suggest a means of exterminating the mosquito, the infecting agent.

He now believes that the mosquito is the finitive host, and man the intermediate host, of the malarial parasite. The cycle of development is then analogous to that of the *tænia solium* and the *trichina spiralis*, where swine constitute the definitive host and man the intermediate host.

Ross is quoted as follows: "Needless to say we can never hope to exterminate them by catching and killing them individually. But, fortunately, there is a very vulnerable stage in their career, before they reach their winged condition—that is, when they are water insects—the little wriggling larvæ found in pots and tubs of water, and in stagnant puddles. These larvæ take about a week to mature in the water. When mature, they rise to the surface and become the adult winged insect and fly away. The females feed on men, cattle or birds, and can live for weeks or even months, laying eggs a few days after each meal. Now, it is hopeless to attempt their destruction when they are winged, but our knowledge of their life history leads us to suppose that if we could make arrangements to empty out once a week all the tubs of water, the ditches, the puddles. and wells within a given area, we should be able to exterminate the larvæ within that area at least for a time, and therefore, also, we should be able to exterminate, at least to a great extent, the adult mosquitoes.—Futcher, *American Jour. Med. Sciences*, September, 1899.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans, La.

Inunctions of Creosote for Malarial Fever.—The *Interstate Medical Journal* for August, 1899, is authority for the statement that A. O. Fitzgerald, medical officer in charge of the Station Hospital at Belgaum, has treated twenty-six cases of malarial fever of different grades by inunctions with beechwood creosote. They were all obstinate cases, and resisted the treatment with quinin, arsenic, etc. Among these cases were instances of tertian ague of a severe type, malarial cachexia and "malignant" malaria. The treatment seemed especially indicated where there was much vomiting and restlessness. The method of administration is to take pure beechwood creosote—fifteen to twenty minims for a child of one year, and thirty to sixty minims for an adult. It is mixed with an equal quantity of olive oil, and thoroughly rubbed into the chest, abdomen and axillae. The oil is employed only as a diluent and to counteract the tingling and burning occasionally produced by the creosote.—*Medicine.*

SUBCUTANEOUS AND INTRAVENOUS INJECTIONS OF QUININ.—Professor Gaglio, of Messina (*Archiv. de Farmacologia e Terapeutica*, Vol. VI., No. 6), recommends the following solution:

℞ Quinin hydrochlor	3 parts.
Urethane	1½ parts.
Aquae, destil	3 parts.

This solution should be injected warmed. One *c.c.* is equal to 0.4 of quinin hydrochlorate. The solution is neutral, does not irritate and keeps well. The addition of the urethane makes the quinin salts easily soluble. Any effect of the urethane can not be noticed in such small quantities. If, in addition to the action of the quinin, the soothing influence of urethane is also required, the quantity of the latter can be increased. Another good formula is the following:

℞ Quinin hydrochlor	2 parts.
Phenocoll hydrochlor	2 parts.
Aquae destillatae	4 parts.

To be injected lukewarm.

In this formula the action of quinin is combined with the antipyretic action of phenocoll.—*The Therapist.*

CACODYLIC MEDICATION.—Danlos (*Revue de Thérapeutique*, July 1, 1899), having ascertained the almost complete innocuousness of cacodylic acid, prescribes it in large doses for the treatment of cutaneous diseases. For internal use he recommends the following formula:

℞	Sodium cacodylate	2 grams
	Dykum	20 grams
	Simple syrup	20 grams
	Distilled water	60 grams
	Essence of peppermint	2 drops

One teaspoonful represents ten centigrams (1 1-2 grains) of sodium cacodylate.

Danlos also uses a pill of sodium cacodylate ten centigrams (1 1-2 grains) and extract of gentian q. s. For hypodermic use he recommends:

℞	Morphin muriate	0.025 grams
	Cocain muriate	0.10 grams
	Sodium chloride	0.20 grams
	Sodium cacodylate	5 grams
	Carbolic acid (5 per cent. sol.)	2 drops
	Distilled water q. s. ad	100 *c. c.*

Danlos has given internally to male patients every day during several consecutive weeks from 40 to 60 centigrams (6 to 10 grains) of cacodylate, and 30 centigrams (5 grains) to females. For hypodermic use he does not go beyond 40 centigrams a day, which dose, however, may be continued for two consecutive months.

In this manner we may, without any danger, give our patients tremendous doses of arsenic. Cacodylic acid and cacodylate of soda are very soluble, containing 50 per cent. of arsenic, and are possessed of a low degree of toxicity. Moreover, in subcutaneous injections they give rise to practically no pain.

The only untoward result of their administration by way of the mouth are a garlicky taint of the breath, most offensive stools and with large doses bowel colic and exfoliating dermatitis. In sixty cases of psoriasis results have been most encouraging, though relapses are not scarce, and new patches occur during the course of treatment, so that cacodylic acid can not be considered a specific in psoriasis.—*The Medical Age.*

The Action of Quinin on Malarial Parasites.—The action of a 1:1500 solution on the parasites in the blood of a patient with quartan fever has recently been made by Le Monaco (*Lo Sperimentale*), and he has found that these parasites have been much altered in their shape. The pigment granules were seen in lively motion and the parasites abandoned the cells, but remained in close proximity. He deducts from his observations that the parasite is driven out of the corpuscle by quinin, and that, therefore, the best time to administer it is during the fever-free intervals, at which time only young parasites circulate in the blood.—*The Medical Age.*

THE COMPOSITION OF THIOCOL (potassium guaiacol-sulphonate Roche) is shown by the formula C_6H_3, OH, OCH_3, SO_3K. It occurs as white microcrystalline, odorless, permanent powder of a faint bitter saline, but not disagreeable taste. It is readily soluble in water and dissolves also in diluted alcohol, but it is insoluble in ether or fatty oils. Its aqueous solution is colored violet-blue by ferric chloride, the color changing to wine-yellow on the addition of ammonia water.

Thiocol has a powerful reducing action on silver salts and ferric compounds, and at once decolorizes permanangate solution. On being oxidized with the latter the benzene nucleus is split off and destroyed, while sulphate, oxalate and carbonate of potassium appear in the filtrate. After the administration of thiocol, almost the total amount of sulphur from the medicament is found in the urine as sulphate with a small proportion of guaiacol-sulphonate.

Careful physiologic experiments made by Dr. G. Rossbach at the Medico-Chemical Institute connected with the high School at Berne, Switzerland, and by Professor Jaquet at the Medical Clinic of the University at Basle, Switzerland, have demonstrated that thiocol, given per os or injected subcutaneously, is non-toxic, produces a striking increase in weight, and shows no injurious influence on the composition of the blood.

On the contrary, in most cases there was an increase of blood corpuscles and hemoglobin; in some instances the quantity remained unchanged. Furthermore, the animal experiments proved the extreme assimilability of thiocol as against other guaiacol compounds, where only 7 per cent. of guaiacol carbonate was absorbed 70 per cent. of thiocol was assimilated. The conclusions Dr. Rossbach draws from his experiments are briefly as follows:

1. Thiocol has the advantage over other guaiacol preparations of being freely soluble in water.

2. Its solubility in water and its permanence in air allow of its employment in any form, powder, tablet, solution, etc.

3. Thiocol excels all other guaiacol preparations and all the

compounds of creosote in its high capability of being absorbed by the animal system (about 70 per cent).

4. Its non-toxicity, whether administered per os or by subcutaneous injection, is also of great value.—*Merck's Archives.*

DIONIN, ethyl-morphin hydrochlorate (*Merck*), is a new morphin derivative. It occurs as a white, somewhat bitter powder. It is soluble in about 7 parts of water, in about 1.4 parts of alcohol, and in about 20 parts of syrup, while it is insoluble in ether and in chloroform. It is precipitated from its solutions by most of the alkaloidal reagents. Dionin appears to be very serviceable, therapeutically, because it affords neutral solutions which may be advantageously employed subcutaneously. As a general analgesic, dionin is not as reliable as morphin, but it may, nevertheless, be employed in chronic painful affections, either internally or subcutaneously, and as no tolerance or habit is ever established, may shield many patients from acquiring the morphin habit. Its particular sphere of action will, however, doubtless be in the treatment of coughs due to irritation, those of bronchitis of every origin and in phthisic subjects, where it affords, besides, general quiet and good sleep, stimulates expectoration, and appears to exert also a beneficial influence on the night-sweats.

Dionin may be given in doses of from ¼ to ½ gr. several times daily, or in one dose of ½ to 1 gr. in the evening, in solution, syrup, or pill.—*Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING,
New Orleans.

CEREBRO-SPINAL RHINORRHEA.—The description of this rare and peculiar disease has been launched into rhinologic literature as the result of the observations and researches made by Dr. St. Clair Thomas, of London, who recently presented a case of that kind before the British Laryngological Society. The patient was a woman who had for a long while been suffering with a constant dripping of a watery fluid from the nostrils, which when examined proved to be identical with the cerebrospinal fluid. During any temporary cessation of the discharge she suffered with vague headaches disappearing at once upon renewal of the flow. Aside from this the patient was in good health and was annoyed only by the mechanical dripping from the nose.

The diagnosis of the condition from other forms of rhinorrhea depends upon an examination of the fluid. According to Thomson, when this clear fluid is free from taste, smell and sediment, when albumin and mucin are found to be practically absent from it, and when Fehling's solution is reduced by it, no doubt is left as to its origin. The at present accepted theory is that the fluid bursts through the perineural sheaths of the olfactory nerve branches, and that the condition is associated with increased intra-cranial pressure. Local medication offers little hope of success in the treatment.

INTESTINAL DISTURBANCES PRODUCED BY ACUTE OTITIS MEDIA OF INFANTS.—Some very instructive observations on this subject have been recorded by Dr A. Hartman, of Berlin, who arrives at the following conclusions:

1. The otitis media of infants may be accompanied by disturbances of nutrition, as evidenced by dyspepsia and emaciation.
2. Upon evacuation of the contents of the middle ear through paracentesis the disturbances of digestion disappear and an increase of weight follows.
3. Elevation of temperature occuring in the course of intestinal disturbances may be referred to a complication with otitis.
4. In all intestinal affections of infants accompanied by elevation of temperature and reduction in weight an examination of the ears for the possible presence of otitis should not be neglected.

The author agrees with Ponfick, who advances the theory that the intestinal affection is due to resorption of toxic poisons from the exudate in the tympanic cavity, and he substantiates his views by a report of a series of cases where evacuation of the exudate relieved the abdomidal symptoms.—*Archives of Otology.*

ACCESSORY THYROID GLANDS AT BASE OF TONGUE.—Doctor Jacob E. Schadle, of St. Paul, Minn., reported at the last meeting of the American Medical Association some interesting cases of this rare affection. The tumor appears as a firm vascular swelling at the base of the tongue of slow growth, and causing little annoyance aside from the interference with deglutition. In one case seen by the author the tumor appeared in a woman 25 years of age, and upon removal was examined microscopically, and found to be identical in structure with the thyroid gland. In a second case operation was refused by the patient, but the diagnosis was justified by its similarity to the above and other cases reported. Butlin in 1890 recorded eight cases of this kind. The occurrence of an accessory thyroid gland in this situation is explained as follows: It is due to a congenital defect or lack of closure of the thyreo-glossal duct, which is the embryonic origin of the normal thyroid body. The foramen cecum at the base of the tongue is a vestige of this duct. Enucleation of the tumor is usually attended by considerable hemorrhage.—*Journ. Am. Med. Ass'n.*

Medical News Items.

The Southern Surgical and Gynecological Association will hold its twelfth annual meeting in New Orleans on Tuesday, Wednesday and Thursday, December 5, 6 and 7. The members of the profession are cordially invited, and the Journal believes that those near New Orleans should take advantage of the opportunity afforded. The St. Charles Hotel has arranged quite reasonable rates, and the meetings of the association will be held in the parlors of that hostelry.

The local profession have arranged for several forms of enterment, and the list of papers for the scientific part is certainly one full of promise.

Dr. Joseph Taber Johnson, of Washington, will preside over the meeting, at which some fifty distinguished visitors are expected to be present. The program follows:

FIRST DAY, TUESDAY, DECEMBER 5.

MORNING SESSION, 9:30 O'CLOCK.

1 Myomatous Tumor of the External Iliac Vein; with Report of Case. A. M. Cartledge, M. D., Louisville, Ky.
2 Nephrectomy. Howard A. Kelly, M. D., Baltimore., Md.
3 Ureterectomy. J. Wesley Bovee, M. D., Washington, D. C.

4 Renal Calculus. Richard Douglas, M. D., Nashville, Tenn.
5 Serious Complications Following Passage of Urethral Sound. W. E. Parker, M. D., New Orleans, La.
6 Report on Gun-Shot Wounds of the Abdomen with Some Statistics. H. H. Grant, M. D., Louisville, Ky.
7 The History of Pulmonary Insufflation and Artificial Respiration in Intra-Thoracic Surgery by Intubation of the Larynx, with Exhibition of Apparatus and Demonstration of its Applcation. R. Matas, M. D., New Orleans; La.
8 The Technic of Early Operations in Cleft Palate. Jas. E. Thompson, M. D , Galveston, Texas.

AFTERNOON SESSION, 2:30 O'CLOCK.

9 Recto-Vesical Fistula. F. W. Parham, M. D., New Orleans, La.
10 Recto-Vaginal Fistulae. L S. McMurtry, M. D., Louisville, Ky.
11 Vesico-Vaginal Fistula of Large Size—Report of Case. M. C. McMannon, M. D., Nashville, Tenn.
12 Urinary Bladder Met With in Operating for Strangulated Hernia, with Report of Case. W. O. Roberts, M. D., Louisville, Ky.
13 Remarks on Vaginal Hysterectomy. H. S. Cocram, M. D., New Orleans, La.
14 A Unique Specimen of Pelvic Tumor. C. Jeff Miller, M. D., New Orleans, La.
15 A Rare Specimen, with History of the Case. Rufus B. Hall, M. D. Cincinnati, O.
16 Surgical Shock. W. F. Westmoreland, M. D , Atlanta, Ga.

SECOND DAY, WEDNESDAY, DECEMBER 6.

MORNING SESSION, 9:30 O'CLOCK.

17 Biliary Calculi. W. D. Haggard, Jr., M. D., Nashville, Tenn.
18 The Different Phases of Electric Treatment. J. McFadden Gaston, M. D., Atlanta, Ga.
19 The Treatment of Recent and Ununited Fractures of the Femur by Wiring. J. W Long, M. D., Salisbury, N. C.
20 Inflammation of Meckel's Diverticulum, Simulating Appendicitis. Wm. Perrin Nicholson, M. D., Atlanta, Ga.
21 The Immediate Hermetic Sealing of Aseptic Wounds—Is it safe? Is it advised? Henry O. Marcy. M. D., Boston, Mass.
22 Remarks on the influence of Technic upon the Results of Abdominal Surgery. Chas. P. Noble, M. D., Philadelphia, Pa.
23 Some Cases of Injury to the Peritoneum. T. J. Crofford, M. D., Memphis, Tenn.
24 President's Address. Joseph Taber Johnson, M. D., Washington, D. C.

AFTERNOON SESSION, 2:30 O'CLOCK.

25 Experience in Operations for Typhoid Perforations. Hugh M. Taylor, M. D , Richmond, Va.
26 Ligation of Lingual Arteries in Operations for Cancer of the Tongue, with Report of Case. W. S. Elkin, M. D , Atlanta, Ga.
27 Four Interesting Cases of Abdominal Surgery: a, Pancreatic Cyst; b. Hepatic Calculi; c. Fecal Fistulae. Floyd W. McRae, M. D., Atlanta, Ga.
28 Litholapaxy Geo. S. Brown, M. D., Birmingham, Ala.
29 Treatment of Stone in the Urinary Bladder. Hunter McGuire, M. D., Richmond, Va.
30 Craniotomy *versus* Cesarian Section. F. T. Meriwether, M. D., Asheville, N. C.
31 Beef Gall in the Treatmentt of Post Operative Obstinate Constipation and Intestinal Obstruction. F. C. Ameiss, M. D., St. Louis, Mo.
32 Report upon Cases of Spinal Injuries Treated at the Louisiana Charity Hospital. E. D. Fenner, M. D., New Orleans, La.

THIRD DAY, THURSDAY, DECEMBER 7.

MORNING SESSION, 9:30 O'CLOCK.

33 Supra-Pubic Cystotomy. W. L. Rodman, M. D., Philadelphia, Pa.
34 Amputation or Extirpation in Cervical Cancer. Geo. J. Engelmann, M. D., Boston, Mass.

35 A Modification of an Operation for Cystocele.
Geo. H. Noble, M. D., Atlanta, Ga.
36 Bilharzia Hematobia Edwin Walker, M. D., Evansville, Ind.
37 A Plea for Early Diagnosis in Appendicitis.
Archibald Dixon, M D., Henderson, Ky.
38 Intestinal Obstruction, with Cases. J. D. Bloom, M. D., New Orleans, La.
39 Tubercular Peritonitis. S. M. Fortier, M. D., New Orleans.
40 Technic of Brain Surgery. J. D. S. Davis, M. D., Birmingham, Ala.

AFTERNOON SESSION, 2:30 O'CLOCK.

41 Splenectomy, with a Report of a Successful Case.
Chas. A. L. Reed, M. D., Cincinnati, O.
42 True Conservatism in Abdominal Surgery.
Jas. T. Jelks, M. D., Hot Springs, Ark.
43 Some Cases Requiring Abdominal Section for Diagnosis.
J. A. Goggans, M. D., Alexander City, Ala.
44 The Technic of Local Anesthesia for Major Operations.
R. Matas, M. D., New Orleans, La.
45 Report of Two Cases:
Case 1. Seventeen Years Congenital Nocturnal Incontinence of Urine.
Case 2. Pregnancy in Uterus Bicornus.
Geo. H. Noble, M. D., Atlanta, Ga.
46 Treatment of Retrodisplacement of the uterus.
I. L. Watkins, Montgomery, Ala.
47 Phases of Intestinal Fistulæ. J. B. Murphy, M. D., Chicago, Ill.
48 Operations on Liver and Biliary Tract—An Experimental Study.
W. E. B. Davis, M. D., Birmingham, Ala.

THE MEDICAL DEPARTMENT OF TULANE opened on November 2 for the preliminary course, and on November 20 for the regular course. Nothwithstanding the quarantines, the session begins with about 350 students.

THE NEW ORLEANS POLYCLINIC opened November 20 with a good class; the absence of a Christmas intermission will be of advantage to the school.

THE NEW ORLEANS COLLEGE OF DENISTRY has begun quite successfully with a class of twenty-seven students. The central location and the novelty of a dental clinic should very soon provide excellent facilities for this school.

THE EDDY-WOODBURY controversy is still under judgment, with the odds in the latter's favor.

THE LOUISIANA-TEXAS QUARANTINE case has not yet reached a decision.

THE MARINE HOSPITAL SERVICE HAS SENT several of its representatives to European ports (in Portugal especially) to prevent the importation of the plague. Recently a plague-stricken ship reached New York, but prompt measures at quarantine stopped the danger.

THE TRI-STATE MEDICAL ASSOCIATION OF MISSISSIPPI, ARKANSAS AND TENNESSEE, will meet in Memphis November 14, 15 and 16. One and one-third fare. All titles of papers should be sent to the secretary, Dr. Richmond McKinney, Porter Building, Memphis.

PUBLIC MONEY FOR CHARITIES.—The *Brooklyn Medical Journal* writes commendably of the Comptroller, Coler, of New York City, for trying to call a halt on the expenditure of public money for charities. The estimate is made that while Philadelphia pays for these institutions $151,000; Baltimore, $227,000; Washington, $194,000; Boston, Milwaukee, Cincinnati, Cleveland and Pittsburg, nothing, New York pays no less than $3,000,000.

RICHMOND IS TO HAVE A NEW HOSPITAL on lines as large as the Charity Hospital in New Orleans. This kind of a hospital has been a desideratum in Richmond for some time, for both teaching and pure surgery purposes.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Thoracic Resection for Tumors growing from the bony wall of the Chest. By F. W. PARHAM, M. D., New Orleans, La.

This monograph which has recently been given to the profession by Dr. F. W. Parham, needs only the mention of the author's name to assure its completeness. If the first few pages alone had been published, enough would have been written to make the article valuable.

The subject has been exhausted by Dr. Parham, and with few exceptions every case of thoracic resection for tumors is cited. Every phase of the subject is dealt with in a thorough manner and the results are clearly summed up by the author. Parham's first case was an accident; he had not seen the patient before she entered the operating room, and the diagnosis was not made until the operation was begun, but the incision made, the operation must be completed. The result speaks for itself.

The first pages of the article depict in most graphic terms the horrible picture that confronted him, a picture familiar to every surgeon who had performed this operation.

By a strange coincidence another case soon presented itself. This was not an accident; the patient had long been an inmate of the hospital, but none had the temerity to undertake the operation until Parham determined upon the step.

In our opinion this single operation has done more for the advancement of thoracic surgery than any single procedure up to this time. The operator, profiting by the experience of others, and bringing to his aid every modern device, went through this hazardous undertaking with comparative ease. A careful review of this case (page 97) will show conclusively the great value, in fact, the absolute necessity, of the Fell-O'Dwyer apparatus.

Although the operation in the first case was less extensive and in no way to be compared to the second, the latter was performed with more facility and less risk.

The arrangement of the work is admirable. The grouping of the cases by years and the division into, first, those in which the pleural cavity was not opened; and, second, those in which the pleural cavity was opened, makes it more valuable as a book of reference. To quote from the first group of cases would occupy too much space, but in the second group we find much of interest.

It was Richerand who first demonstrated that the pleural cavity could be opened successfully. In the report of his case, operated upon in 1818, prior to the days of either antiseptic surgery or anesthesia, we find a history that reads almost like fiction. On page 30 the surgeon describes the great difficulty and anxiety which immediately followed the entrance of air into the pleural cavity. "I sought," says he, "by placing thereto the left hand to moderate the entrance of air and to prevent suffocation, which appeared imminent." Each case which has followed contains points of interest with special reference to this condition. Case No. XI (page 37) is the famous Fischer case, operated upon in 1878, in which such valuable observations were made by Von Ziemsen on the human heart. In this case, too, collapse of the lung followed opening of the pleural cavity, almost terminating the life of the patient.

A comparison between Parham's two cases will suffice to prove clearly the necessity of the Fell-O'Dwyer's apparatus in operating when the pleural cavity is opened. In reporting the first case (page 93) Dr. Parham says: "The air rushed in and collapsed the lung completely. It could be seen at the bottom of the cavity against the vertebral column and mediastinum, making, it is true, feeble efforts to do its share of the work, but it was practically eliminated from the labor of respiration. The condition for a time was extremely grave, and death on the table seemed imminent, the pulse almost disappearing." To combat this terrible condition the means at hand proved useless.

Now let us quote from Parham's second case (page 98): "A second attempt was made to clear the first rib at another point. * * * The pleura was again torn and the patient showed signs of collapse. * * * The pulse almost disappeared, * * * the patient becoming blanched and showing all the signs of profound shock. As soon as the tube (of the Fell-O'Dwyer's apparatus) was inserted, and the apparatus working, the lung began to recover itself, and the man's condition at once improved. The assistance rendered by the Fell-O'Dwyer apparatus was evident to all. Whenever there was a hitch in the working of the apparatus the lung showed signs of collapsing, but when the apparatus was working the respiration was almost as regular as the normal breathing. It was observed by all present that the lung expanded in expiration and fell back in inspiration."

This is the only case in which there was little difficulty in respiration following the operation. The comparison of these two cases, we feel certain, is sufficiently laudatory of this apparatus.

It is impossible in this review to quote the statistics or discuss further the merits of this monograph. We feel our inability to do full justice to the subject, and to appreciate its value one must read it. As we have stated, every phase of the subject is dealt with, and with such thoroughness that too much can not be said in its praise.

It is not alone a compilation of statistics and report of cases. The author has drawn his own conclusions, and has done this in such a conscientious manner as to make his labor not only valuable to others, but a credit to himself. It is a valuable addition to any surgical library.

MARTIN.

The Treatment of Pelvic Inflammations Through the Vagina. By WM. R. PRYOR, M. D. W. B. Saunders, Walnut street, Philidelphia, 1899.

This is a small book of 240 pages that contains much of a familiar nature to physicians, but much that is to them new, and that requires careful consideration.

The former consists of a study of the etiology, and pathology of inflammatory diseases of the female pelvic organs, and as there is here scarcely anything new presented, this part of the book can well be left uncommented on.

But the conditions are different with that part of the book which deals with the treatment of such diseases, and the reviewer owes it both to the author and to physicians to carefully weigh the meaning and importance of every advice or suggestion herein found.

Ignoring curettage and other well-known methods, attention will at once be directed to what the author calls his own methods of treating inflammatory diseases of the tubes and ovaries. The first is that of Exploratory Vaginal Section for diagnosis, which consists of a posterior colpotomy with various subsequent steps. After the usual preparation, the patient is "only partially" anesthetized, the usual speculum and retractor are introduced, the vaginal wall cut with scissors, the peritoneum caught with tissue forceps and cut with scissors, next the opening is enlarged with the fingers that make an exploration of the pelvic cavity. The next step consists in introducing special retractors, applying forceps to bleeding points, introducing strips of gauze into the pelvic space and making a *visual* examination of the diseased appendages (which are at times drawn down with forceps), after the uterus has been completely lifted with a special retractor. In commenting on the above advised procedure, the reviewer must acknowledge his inability to understand how a *visual* examination of the pelvis can be made through a one and a half inch opening that contains forceps, retractors and strips of gauze! It is extremely difficult to understand how adherent appendages can be drawn down with forceps without tearing them, and it is also difficult to understand how a retroverted adherent uterus can be elevated without breaking up the adhesion or risking great traumatism. And yet the author advises against such breaking of adhesions until after the examination. And finally, it is hard to comprehend how such delicate work can de done in ten minutes on a woman with a small vagina, or who is only "partially anesthetized." To adopt such a method of examination, except in extremely rare instances, would possibly indicate a sad lack of skill in safer and very satisfactory methods, and in the hands of one lacking such skill, must be dangerous.

As a conservative treatment of acute inflammation of the adnexa uteri he advises posterior colpotomy, breaking down adhesions, curettage of uterus, temporary packing with gauze of the detached tubes, and subsequent packing of the pelvic cavity. Now, any one with the slightest experience with salpingitis will appreciate the almost insurmountable difficulties attending any attempt at packing an inflamed tube with gauze from fimbria to uterus, through an opening in the vaginal wall. The bend produced in the tube would interfere with such procedure. And to believe that such treatment will cure *every* case of acute pelvic inflammation is almost an impossibility.

We can not agree with the author that such an operation can be performed with ease, or that it is free from danger.

Nor can we agree with his assertion that "to deny this operation to a woman is to refuse to believe that her most highly vitalized organs have power to repair when aided by incision and drainage." Nor can we accept his statement that three feet of gauze, one inch wide, can be housed into a uterine cavity, two and a half inches long.

It is impossible to give attention to every surgical treatment he recommends, and therefore further reference will be made only to his method of performing vaginal hysterectomy.

This operation he performs by a preliminary hemisection of the uterus, thereby, as he calls it, dividing his difficulties. By this method, while one-half of the organ is being removed, the other half is pushed up into the pelvic cavity. While a decided manipulative advantage is no doubt gained, it is questionable whether a greater risk of infection is not incurred. In our experience nearly every case requiring removal of the organ was associated with more or less infection of the endometrium.

It is true that the infected material can, to a very great extent, be removed by proper curettage. The operation evidently deserves trial.

From his report Dr. Pryor is certainly a very skilful operator.

He is the inventor of several very clever instruments, and an excellent portable operating table.

The book is well illustrated, well written, and deserves careful reading.

MICHINARD.

Diseases of the Ear, Nose and Throat. By D. BRADEN KYLE, M. D. W. B. Saunders, Publisher, Philadelphia, 1899.

Following somewhat the example set by many writers of the day, the author of this volume has endeavored to produce a work to be equally as valuable for the student as for the advanced specialist, and has succeeded admirably well. Attention is given to detail in the recognition and treatment of the commoner affections, and at the same time the rarer important subjects are thoroughly treated. As a reference book its value lies as well in its completeness as in the facility with which the various subjects may be found. For this purpose each chapter is prefaced with a classification of the contained matter. The text is profusely embellished with original illustrations and lithographs, and deserving attention is given therapeusis and the choice of instruments.

A valuable chapter is that on laryngeal surgery, contributed by the able pen of Prof. W. W. Keen, of Philadelphia.

The work is creditable enough to deserve a fitting place among the standard text-books of the day in this branch of medicine.

DEROALDES AND KING.

A Compend of Gynecology. By WM. H. WELLS, M. D. Illustrated; P. Blakiston's Sons & Co., Philadelphia, 1899.

This is the second edition of this book, and is practically the same as the first. The numerous illustrations have all, or nearly all, been taken from various text-books, but without due credit being given them.

The student will no doubt find in this little book a good assistant to his studies of gynecology. It is worth the price asked, 80c. MICHINARD.

A Compend of the Practice of Medicine. By DANIEL E. HUGHES, M. D. Sixth Edition; P. Blakiston's Sons & Co., Philadelphia, 1899.

This useful work needs no introduction. The sixth edition is thoroughly revised and enlarged wherever such improvement seemed to be suggested. It is the best *vade mecum* we know. As stated in the preface, it has been the author's aim to give the profession as complete a compend of the whole field of practice as possible, and not a treatise on general medicine; nevertheless, much valuable and trustworthy information is to be found between the covers of the book. DYER.

Mémoire sur la bactériologie, pathogénie, traitement et prophylaxie de la fièvre jaune par le Dr. Domingos Freire, *directeur de l'Institut bacteriologique de Rio de Janeiro*, 1898.

Dr. Domingos Freire, recently deceased, has an unquestionable right to the title of pioneer of bacteriologic researches on yellow fever. His micrococcus xanthogenicus may not be the germ; his bacterial treatment, his sero-theraphy and his preventive inoculations may have failed; but, the fact remains that he worked in the right direction according to modern views. His idea of vaccination is acceptable. Think of our faith in vaccine against variola; see the unquestionable good results of Haffkine's vaccinations against the bubonic plague; hear just at present the talk of anti-typhoid inoculations in the British army as having given positive results. Of course, the question is to find the germ, or the ferment. After all, it may be soothing to the doctor's legitimate pride to know that even Sanarelli's latest researches are yet *sub judice* in many high departments of science, outside of the United States.

Dr. Domingos Freire is entitled to our most respectful regard and deserves our thanks.

Dupaquier.

The Practice of Obstetrics by American Authors. Edited by Charles Jewett, M. D., Professor Obstetrics in the Long Island College Hospital, New York. Illustrated with 441 engravings, etc. Lea Bros. & Co., New York and Philadelphia, 1899.

As a modern and practical work of obstetrics this book deserves hearty recommendation. What might appear to one individual reader as deficiencies, slight inaccuracies or exaggerations, to another might seem otherwise. Too analytic a view should not be taken of so extensive a work, but it should be looked at with a broad view and judged of as a whole. It is full of practical and valuable suggestions, and will, no doubt, prove a reliable teacher. Michinard.

PUBLICATIONS RECEIVED.

Report of Commission of Medical Officers Detailed by Authority of the President to Investigate the Cause of Yellow Fever—Washington, 1899.

Yellow Fever, Its Nature, Diagnosis, Treatment and Prophylaxis, and Quarantine Regulations Relating Thereto, by officers of the United States Marine Hospital Service—Washington, 1899.

Enlargement of the Prostate, Its Treatment and Radical Cure, by C. Mansell Moullin, M. D.—P. Blakiston's Son & Co., Philadelphia; H. K. Lewis, London, 1899.

International Clinics, Vol. III, Ninth Series—J. P. Lippincott Company, Philadelphia, 1899.

The Abdominal Brain and Automatic Visceral Ganglia, by Byron

Robinson, M. D.—The Clinic Publishing Company, Chicago, 1899.

A Laboratory Manual of Physiological Chemistry, by Elbert W. Rockwood, M. D.—The F. A. Davis Company, Philadelphia, New York, Chicago, 1899.

Practice of Medicine, by George E. Malsbary, M. D. Series edited by Bern B. Gallaudet, M. D.—Lea Brothers & Co., Philadelphia and New York.

Annual Report of the Supervising Surgeon-General of the Marine Hospital Service of the United States for the Fiscal Year 1897—Washington, 1899.

Essentials of Diseases of the Skin, by Henry W. Stelwagon, M. D.—W. B. Saunders, Philadelphia, 1899.

Essentials of Medical Chemistry, by Lawrence Wolff, M. D.—W. B. Saunders, Philadelphia, 1899.

Text-Book of Materia Medica, Therapeutics and Pharmacology, by George Frank Butler, M. D.—W. B. Saunders, Philadelphia, 1899.

A Text-Book of the Practice of Medicine, by James M. Anders, M. D.—W. B. Saunders, Philadelphia, 1899.

Disases of Children, by George M. Tuttle, M. D., Edited by Bern B. Gallaudet, M. D.—Lea Brothers & Co., Philadelphia and New York.

Progressive Medicine, Edited by Hobert Emory Hare, M. D., Vol. III., 1899.—Lea Brothers & Co., Phiadelphia and New York.

The International Text-Book of Surgery by American and British Authors, Edited by J. Collins Warren, M. D., and A. Pearce Gould, M. D., Vol. I.—W. B. Saunders, Philadelphia, 1899.

A Treatise on Surgery by American Authors, Edited by Roswell Park, M. D.—Lea Brothers & Co., New York and Philadelphia, 1899.

Preliminary Catalogue of Plants Poisonous to Stock, by V. K. Chesnut, B. S.

The Courier of Medicine, Pocket Reference Book and Visiting List.—Courier of Medicine Company, St. Louis, Mo., 1900.

Over 3000 Questions on Laws of the Human Body or Physiology, by Prof. J. P. Schmitz, M. D.—San Francisco, California, 1899.

Physiology, by Howard D. Collins, M. D. and Wm. H. Rockwell, Jr., M. D.—Lea Bros. & Co., Philadelphia and New York, 1899.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR OCTOBER, 1899.

CAUSE.	*White.....*	*Colored...*	*Total .....*
Fever, Malarial (unclassified)	4	2	6
" " Intermittent	....	....	....
" " Remittent	2	....	2
" " Congestive	9	1	10
" " Typho	3	1	4
" Yellow	11	....	11
" Typhoid or Enteric	12	4	16
" Puerperal	1	1	2
Influenza	....	....	....
Measles	1	....	1
Diphtheria	3	....	3
Whooping Cough	....	....	....
Apoplexy	7	5	12
Congestion of Brain	2	3	5
Meningitis	5	1	6
Pneumonia	24	15	39
Bronchitis	4	3	7
Cancer	13	7	20
Consumption	32	34	66
Bright's Disease (Nephritis)	21	22	43
Uremia	2	2	4
Diarrhea (Enteritis)	24	7	31
Gastro-Enteritis	5	1	6
Dysentery	3	2	5
Hepatitis	3	....	3
Hepatic Cirrhosis	7	1	8
Peritonitis	6	4	10
Debility, General	2	....	2
" Senile	10	4	14
" Infantile	1	3	4
Heart, Diseases of	35	17	52
Tetanus, Idiopathic	....	....	....
" Traumatic	2	2	4
Trismus Nascentium	5	3	8
Injuries	15	14	29
Suicide	2	....	2
All Other Causes	93	39	132
TOTAL	369	198	567

Still-born Children—White, 19; colored, 12; total, 31.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 21.08; colored 26.40; total, 22.68.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.05
Mean temperature	71.
Total precipitation	.089 inches

Prevailing direction of wind, northeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LII. JANUARY, 1900. No. 7.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

A REVIEW OF THE BACTERIOLOGY OF GONORRHEA.*

By O. L. POTHIER, M. D.,

PATHOLOGIST TO CHARITY HOSPITAL, ETC., NEW ORLEANS.

The gonococcus was discovered in gonorrheal pus by Neisser in 1879. Baum cultivated it in artificial media in 1885, and proved its virulence by inoculation into man. It was also isolated by Wertheim in 1893 on a special culture medium. It has been further investigated by Finger, Ghon, Schlagenhaufer, Heiman, and De Christmas in 1897.

Morphology.—They are micrococci, usually joined in pairs or in groups of four—biscuit-shaped. It measures 0.6 to 1.6μ in the long diameter, the average being 1.25μ, and from 0.6 to 0.8μ in the line of interspace separating the cocci. Multiplication in pairs alternately in two places, the result being groups of four. The arrangement in diploccocci is more numerous and is considered characteristic. This description of its morphology is not sufficient to totally distinguish it from other cocci.

Stains.—It is quickly stained with basic anilin dyes, especially methyl violet, gentian violet and fuchsin; not so quickly with methylen blue, which, however, is one of the best stains. The double stain with eosin is advisable. The method employed at the Charity Hospital, and which gives good practical results, is the following: The specimen is first stained with methylen blue (Lœffler's solution) for 15 to 20 seconds, and then, after washing and drying, is stained in an alcoholic solution of eosin composed of 12 per cent. eosin in 50 per cent. alcohol. The organism does not stain by Gram's method, and this is a distinguishing test, though not to be wholly depended upon; it must be coupled with the fact that the gonococcus is found within the pus cells. This last characteristic is typical with one exception, which is a coccus found by Baum in a form of puerperal cystitis; this last coccus, however, stains by Gram's method, which fact distinguishes it from the gonococcus.

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*Read at the Orleans Parish Medical Society, November 25, 1899, as a part of a general discussion on gonorrhea.

Cultivation.—It does not grow on the ordinary culture media. According to Finger, Ghon and Schlagenhaufer, it grows well on Pfeiffer's serum-agar, best on urine-agar, and the growth is favored by acids. According to Heiman, urine-agar is not a favorable medium. Wertheim's medium, which is agar-serum, is considered by all investigators as a good medium. The best medium and the one that gives the best results, is rabbit's serum, and for obtaining the toxins, the ascitic fluid with peptonized bouillon and with the addition of very slight amount of glucose, is the best medium. According to the view of De Christmas, the media must be alkaline, whatever may have been said to the contrary, the mediums prepared by Finger, albuminous urine, and agar, he considers of no value. Whatever may be the culture medium, it is essential that it should contain albumin.

The organism develops best at a temperature of 36 deg. C., the limits being 25 deg. C. to 39 deg. The cultures are at best short lived in most culture media, so that a replant after the fourth day remains sterile. Replanting then becomes necessary every forty-eight hours. On rabbit's serum, however, they live longer; at times as long as two months, even after drying of culture medium to dessication. On ascitic culture medium the cultures continue to grow until the seventh or eighth day, when they have attained their maximum of growth; replanting at this moment, the new cultures remain sterile.

Pathogenesis.—From the experiments of Baum, and others since, it is now generally admitted that the gonococcus is the specific cause of gonorrhea.

The penetration of the gonococcus to the deeper layers of the mucous membrane of the urethra, and even into the corpus cavernosum has been observed by Bocklan in a case in which death occurred during an acute gonorrhea; this is unusual, the invasion being limited to the superficial layers of the mucous membrane. Its behavior varies with the nature of the epithelium of the mucous membrane; on membranes covered with squamous epithelium it remains superficial; if applied to mucous membrane lined with cylindric epithelium it soon penetrates into the connective tissues. Reports of the discovery of the gonococcus in various parts of the body, such as mouth, rectum and serous cavities, must be looked upon with skepticism, owing to the fact that Gram's stain was not applied.

The gonococcus is pathogenic to man alone, all inoculations of animals having given negative results. Even the intraperitoneal cultures in collodion sacs do not increase its virulence. It grows well in the sac, but after inoculation into an animal it stops growing and dies. No method of inoculation usually employed to render animals susceptible to infection gives better results. The immunity may be explained partly by the sensitiveness of the organism to high temperature, which in the rabbit is above 39 deg. C., while that of the guinea pig is 38.5 deg. C., and partly by the fact that the gonococcus does not propagate in living fluids or in fluids recently extracted from the body, while these same fluids heated and coagulated become excellent culture media.

If this be true of the gonococcus cultures when injected into animals, it is not of the toxin produced by this organism. When this toxin is used it produces intoxicating and inflammatory phenomena, which are very marked, and which may produce immediate death, or a slow cachectic condition, resulting in death.

In the rabbit the injection of from 10 to 20 *c.c.* of toxin produces an inflammatory swelling, which remains swollen and painful for as long as a month after the injection, and may become the origin of abscesses, which are considered as secondary infections and due most probably to diminished resistance of the tissues, which is produced by the toxin. In younger animals (rabbits 1 month to 6 weeks old) these abscesses are due directly to the toxin since the pus in these is sterile. They remain circumscribed and disappear by absorption without leaving any lesions of the tissues. The local condition is not the only manifestation of the toxin, since the animals refuse to eat and remain quiet while the temperature reaches as high as 40.5 deg. *C.* There is a rapid loss of weight, from 150 to 200 grams for the first twenty-four hours in an animal of 2000 to 2500 grams, the original weight being restored in ten to fifteen days. If the injections are continued at slow intervals the animals gradually continue to lose weight and become markedly cachectic, bringing the animal down to one-fifth of its original weight. From this condition they very slowly recuperate, and more frequently die in a state of complete marasmus. There is no special lesion at the autopsies, the most characteristic phenomenon being a marked anemia with great diminution of the red corpuscles.

If the injections are practiced intravenously, these symptoms are intensified if they are of 1 to 2 *c.c.* When 5 *c.c* or more are given there are symptoms of collapse, with subnormal temperature. At the autopsy of these cases the only prominent lesion is the acute congestion of the lungs, which is the probable cause of death.

The loss of weight is characteristic, and is a means by which we may judge of the degree of immunity conferred to animals, and also a mensuration of the antitoxic value of the serum of immunized animals.

I have copied three charts, giving the weights of animals and the effect of the toxins on them.

Chart No. 1 gives the result of inoculation of three rabbits, rabbit A having received 2 *c. c.* of toxin per kilo in the vein; rabbit B having received the totality of gonococci in a culture of 100 *c. c.* and in their own culture medium, the culture being 10 days old; rabbit C has received 5 *c. c.* of sterile culture medium.

From these experiments the gonococcus toxin is established. It will stand heating to 70 deg. C. It is precipitated by alcohol and the albumin carries with it the toxic properties of the toxin. The toxin is prepared by evaporation of water, both at 50 deg. C, and is mixed with 1-10th of glycerin. This solution retains its properties six months after if kept out of the light.

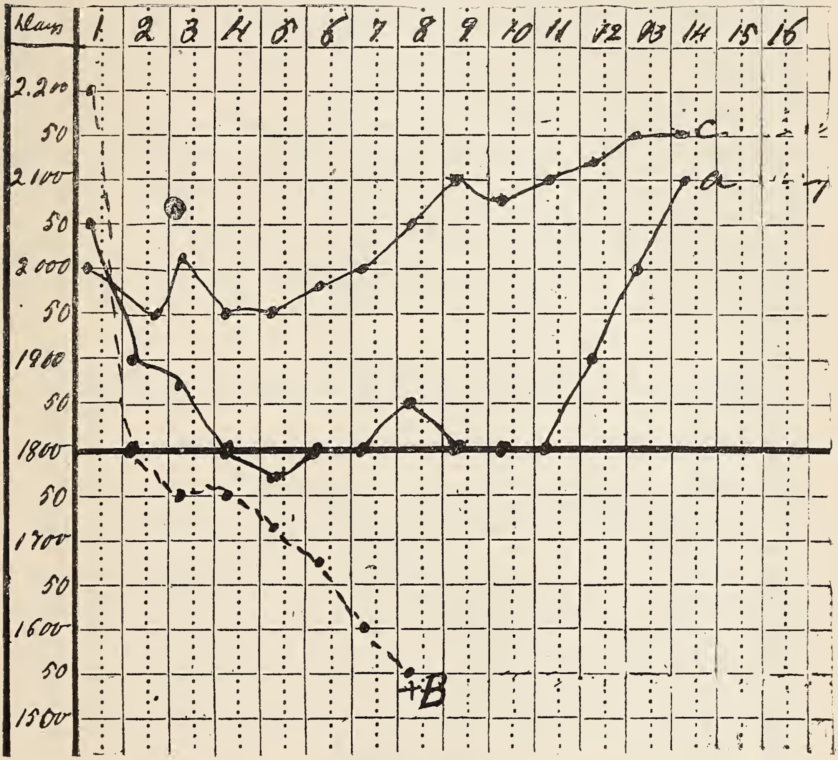

CHART NO. I.

a—2 *c.c.* per kilo in vein.
B—Death—Emulsion of gonococci in a culture of 100 *c.c.* of bouillon 10 days old.
c—Controle injected with 5 *c.c.* sterile ascitic of bacillus.

Column of figures on left show weight in kilos.

The lesions at the autopsies of animals dying after inoculations of this toxin are edema of the kidneys, slight effusion in the peritoneum, congestion of lungs; liver and spleen normal.

If, instead of intravenous injections, the toxin is applied to anterior chamber of the eye, or to serous membranes, violent inflammation with suppuration ensues, the pus being, as a rule, sterile.

Application to the human urethra produces a characteristic, acute, purulent secretion, which is remarkable on account of its acuteness and the rapidity with which it develops. It reacts in 4 hours. There is no immunization of the human urethra.

Immunization of animals by intravenous injections is possible and Chart No. II gives a graphic reproduction of the reaction. The points marked with a cross are the days of injection, and these were of 2.5 *c.c.* at each injection.

Anti-toxin was obtained from goats which had been immunized during a whole year and which received 3200 *c.c.* of toxin. The value of the antitoxic serum is lessened if taken during the period of intoxication.

Chart No. III gives an idea of the preventive action of the anti-toxin. It prevents also the inflammatory phenomena of the eye and in the heart.

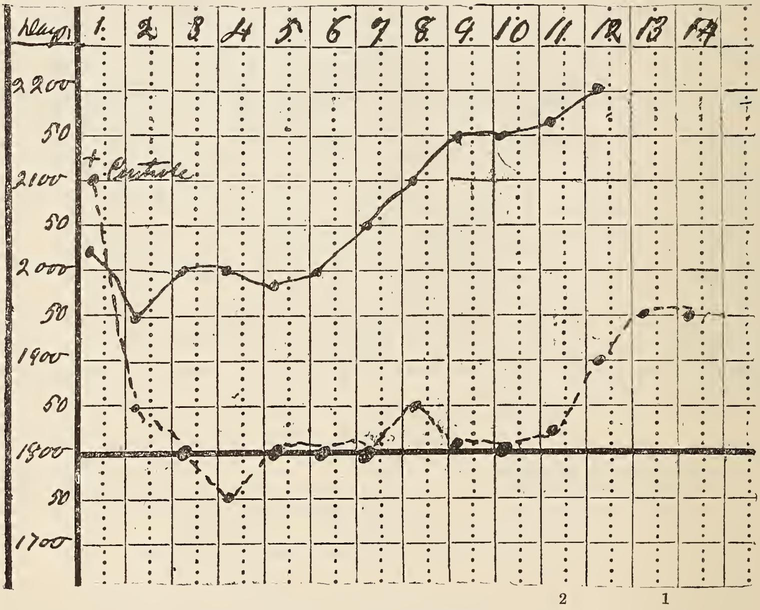

CHART NO. III.

1—Inoculated with toxin alone.
2—Inoculated with anti-toxin four hours before inoculation of toxin.

Figures on left show weights in kilograms.

From the foregoing we may conclude:

1st. That the gonococcus is the specific cause of gonorrhea.

2nd. That they produce a virulent toxin.

3rd. That the effect of this toxin on the tissues may produce changes in them allowing access of other septic organisms which may become more dangerous after the action of the toxin.

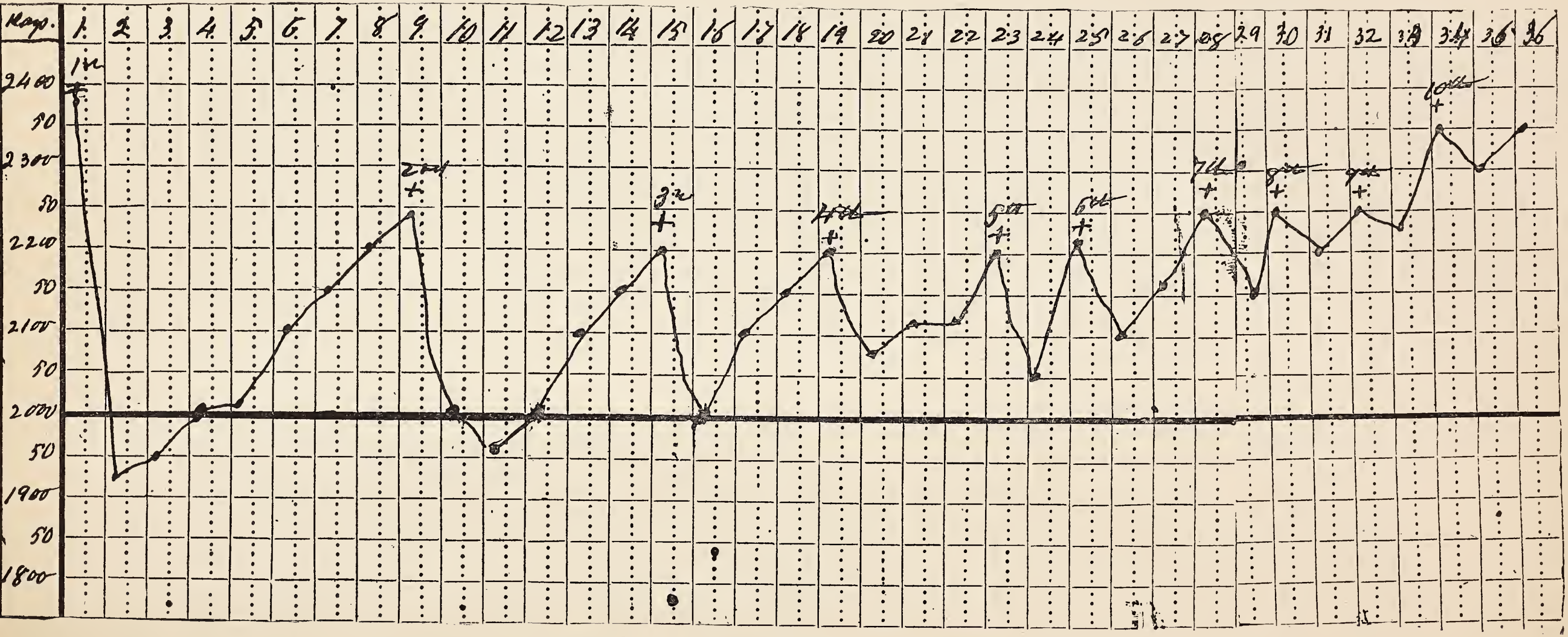

CHART No. II.—(DR. POTHIER'S PAPER.)

FIGURES ON LEFT SHOW WEIGHTS IN KILOGRAMS.

REPORT OF CASES OF SPINAL INJURY TREATED AT THE CHARITY HOSPITAL, NEW ORLEANS, DURING 1899.*

By E. D. FENNER, M. D., First Assistant House Surgeon Charity Hospital; Lecturer and Clinical Instructor on Diseases of Children, Medical Department, Tulane University, New Orleans.

In looking over the records of the Charity Hospital for 1899 I have been able to find reports, more or less complete, of fifteen cases of spinal injuries. The following is a summary of the history of these cases:

No. 1, John Nolan, white, aged 44 years. Admitted May 16, 1899. Contusion of lumbar region. Partial paraplegia. Discharged, improved, May 22, 1899.

No. 2, Henry D., white, aged 30. Admitted May 16, 1899. Discharged May 17, 1899. Fracture dislocations of third cervical vertebra.

This young man was found upon the street, unconscious, by the police. Suspecting something more than alcoholism, the ambulance was summoned and he was sent to the hospital. On his arrival he had regained consciousness, but was very boisterous, throwing himself about and behaving generally like a man far gone in liquor, which indeed he was. Pain and tenderness in the neck indicated an injury in the cervical region, and he was put to bed with a sand-bag on either side of his head. Next day a fracture, with some displacement of the bone, was readily made out. Chloroform was given, the neck stretched and a plaster-of-Paris collar applied. He presented at this time paresis of the right upper extremity and complained a great deal of pain in his neck. He was taken to his home, where I am informed after a time a Davis wryneck brace was substituted for the collar. In the course of six weeks he was able to discard the support and now appears to be entirely well, except for some deformity at the seat of injury and some stiffness of the neck. In what manner the injury was received we have never been able to discover.

No. 3, Louise Calamari, white child, admitted May 25, 1899. Died within an hour. Extensive fracture of vault and base of skull; fracture third cervical vertebra.

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* Read before the Southern Surgical and Gynecological Association, New Orleans meeting, December 5, 6 and 7, 1899.

No. 4, Henry Crocha. Admitted May 31, 1899; died June 7, 1899. Gunshot wound of chest and spine. Paraplegia.

No. 5, Lucie Dufour, aged 80 years. Admitted June 14, 1899; died June 21, 1899. Cervical spinal injury. Paraplegia.

No. 6, Manuel Blanco. Admitted August 29, 1899. Fracture of lamina of third dorsal; dorso-lumbar dislocation. In attempting to board a freight train he was thrown violently against the side of the station platform, striking his back and head. The ambulance conveyed him to the hospital.

Examination revealed pain and tenderness in the back and legs. Motion and sensation were not impaired, but a fracture of the third dorsal lamina and a dorso-lumbar dislocation of the spine were found. He was put to bed with one long, narrow sand-bag beneath the back and two others on either side. Four days later, under chloroform anesthesia, it was attempted to reduce the dislocation, and a plaster cast was applied. The patient was exceedingly restless, and in the course of a week had torn the cast to pieces. For two weeks he was left without any support, being simply confined to bed. But as he suffered considerably with his back, a new cast was at this time applied. This relieved his pain, and was worn for about four weeks. He then got about without support for a time, but complained of pain after being up for a few hours. On November 22 a new cast was applied, which at once relieved his suffering, and he now goes about without any trouble. A distinct irregularity in the spinous processes is evident at the seat of the dislocation.

No. 7, Peter Ambry, colored, aged 63. Admitted August 30, 1899. Died September 3, 1899. Injury, cervical vertebra, paraplegia, Pott's fracture of ankle.

No. 8, Sidney Lewis. white, aged 7 years. Admitted September 2, 1899. Discharged September 28, 1899. Fracture, dislocation third cervical vertebra. This child fell from a gallery fifteen feet high, striking upon his head and shoulders. He suffered a subcoracoid dislocation of the left shoulder and fracture of the third cervical. The grating of the lamina could be distinctly felt and projection of the displaced vertebral body could be detected by the finger in the pharynx. There were no paralytic symptoms. Under chloroform the displacement was corrected, and the neck put up in a plaster cast, which included the injured shoulder. Recovery was uneventful and the child was discharged apparently entirely well.

NO. 9, ALEX GARNER. Admitted September 22, 1899. Died October 1, 1899, sub-luxation lumbar vertebra.

NO. 10, JAMES CALLAHAN, aged 26 years. Admitted September 4, 1899. Discharged October 1, 1899, sub-luxation dorsal vertebra, paraplegia.

NO. 11, WILLIAM JOHNSTON, aged 63 years. Admitted September 5, 1899. Died September 27, 1899, fracture fifth cervical vertebra.

NO. 12, ADOLPH TREME. Admitted September 25, 1899. Discharged November 10, 1899, fracture of lamina lumbar spine, hematuria. This man had partial paralysis of the left lower extremity, which, together with the hematuria, gradually disappeared under treatment by recumbency.

NO. 13, JOHN A. WHITE. Admitted October 17, 1899; discharged stationary October 20, 1899. Fracture dorsal vertebra.

NO. 14, JNO. WALKER. Admitted October 24, 1899; died November 1, 1899. Fracture fourth lumbar. Laminectomy. This man was engaged in chopping down a tree when it fell, striking him across the small of the back. He became unconscious, and when he regained his senses he found himself completely paralyzed from the waist down. Upon his arrival at the hospital we found a fracture of the fourth lumbar, with marked displacement of the column.

He was put to bed and on the 25th of October a laminectomy was done by Dr. Bloom, assisted by myself and the interne staff. Upon exposing the vertebral arches by the usual median incision, a fracture of the lamina of the 4th lumbar was found and this arch was removed with trephine and rongeur forceps. The cord was exposed and found to have been partly cut in two but without injury to the membranes. The body of the vertebra was found to have been fractured and the two segments of the spinal column were freely moveable upon one another. A sharp fragment of the broken body projected into the spinal canal, pressing against the cord. This was removed, the displacement corrected as far as possible, the wound sutured, and a plaster cast applied.

Next morning sensation was restored in both legs and motion slightly restored in the left foot.

The urine, which had to be drawn, contained blood, evidently from the kidney, and soon became very offensive.

Third day after the operation—Temperature has been persistently high. Intestinal paresis, with tympanites; hiccough and delirium have set in. Coma gradually developed and the patient died on the sixth day.

No. 15, Rosario Ferrara, aged 28. Admitted November 7, 1899. Fell from a platform in a sawmill and was struck across the back by a log. Complete paraplegia. Dislocated fracture about eighth dorsal. Under chloroform reduction attempted and partly successful; plaster cast applied; no improvement of condition; fever quickly developed; bed sores formed in a few days; urine decomposing in the paralyzed bladder. Cast removed at the end of a week to reveal pressure sores beneath the cast at the region of spinal injury. This man now lies in bed with paralysis of the sphincters of bladder and rectum, and complete paraplegia from the level of the umbilicus. There is distinct girdle sensation and a zone of hyperesthesia. He is surely doomed to death by exhaustion and sepsis.

An analysis of these cases brings out the following points:

The diagnoses are variously recorded as: Fractures, dislocations, or fracture-dislocations. In most of the cases the injury was probably both a fracture and a dislocation, the heavy covering of soft parts serving in some of the cases to mask one or the other lesion, so that it was not recorded. As might be expected, these injuries were all the result of extreme violence, sometimes direct, sometimes indirect. For instance, I find among the causes: "A fall upon the head and shoulders from a height of 15 feet;" "Struck by a falling tree in the small of the back;" "Thrown from a train, striking side of station platform with small of back."

Of the fifteen cases seven were fatal, generally in a few days. In one case (No. 8) the spinal injury was complicated by (or might be considered a complication of) extensive fracture of the vault and base of the skull, and death occurred within an hour or two from the immediate shock of the injury.

In the list of fatal cases are included all the cases in which there was paraplegia except four. Of these four, one was a partial paraplegia following contusion of the back; one is still in the hospital completely paralyzed from the waist down, with extensive bed sores and a surely fatal prognosis; and two were taken home still paraplegic and have in all probability succumbed since their removal to their homes. The mortality may then be reckoned as ten out of fifteen—66.7 per cent.

The cases having a favorable termination presented physical evidences of injury to the spinal column, but were not attended by apparent damage to the spinal cord, with the exception of one case (No. 2), in which there was partial paralysis (paresis) of one arm, and in which the diagnosis of vertebral injury has been confirmed by the deformity which still remains.

As evidence of the relative vulnerability of the regions of the spinal column, I find that of the fifteen cases the lesion was located as follows:

Cervical, 6.
Dorsal, 4.
Dorsal and dorso-lumbar, 1.
Lumbar, 4.

Our rules for the treatment of these cases at the Charity Hospital are simple. In cases presenting evidence of displacement we endeavor to reduce the deformity under anesthesia, and then secure immobility by the application of a plaster cast or collar. Not frequently do we resort to laminectomy. During 1899 but once was this measure tried, and in this case, as has been the experience here in the past, the termination has been fatal. I am not aware of any case dying during or as an immediate result of the operation itself, but in our hands it has not seemed to favorably influence the progress of the cases in any way. In the laminectomy reported in this series it is noticeable that some return of sensation and motion followed the operation, but the general progress of the case toward death was not affected.

In this connection it is interesting to review the recent expressions of prominent surgeons upon the subject of the operative treatment of these spinal injuries, and to note that the consensus of opinion seems to be the same in all of them.

The *Annals of Surgery* for August, 1899, contains an article by Percival R. Bolton, in which, after reviewing the various forms of injury to which the spinal cord is liable as a result of such traumatism, he announces the following conclusions:

"1. Extradural hemorrhage does not give rise to cord lesions or symptoms, and requires no treatment.

2. Total lesions of the cord are irremediable * * * and require no treatment.

3. In hematomyelia the clot is absorbed * * * There may be great amelioration of the symptoms; there is therefore no therapeutic indication and no remedial treatment is possible.

4. In partial contusion * * * no treatment is available.

5. In open injuries of the cord * * * active operation in perference is indicated to remove foreign bodies to facilitate disinfection, to prevent more extensive necrosis, and facilitate drainage."

In the discussion upon the paper which followed at the meeting of the New York Surgical Society, Dr. L. A. Stinson thought that very few cases of fracture-dislocation could be benefitted by operation. Dr. Robert Abbe had seen no benefit from any of the eighteen operations he had performed, with one solitary exception. Other members expressed themselves to the same effect.

These are exactly the deductions we have been forced to draw from our experience here, and it would seem that the outlook from operative intervention in these cases is very bad.

Clinical Report.

REPORT OF A CASE OF BRADYCARDIA.*

By T. S. DABNEY, M. D., Member of the Royal Society of Public Medicine and of Medical Topography of Belgium, etc., New Orleans.

On October the 20th I was hurriedly called to see Mrs. L., aged 65. Patient gave a history of having been very ill for about ten days. Her condition had become so alarming that her children had been summoned from different parts of the State to bid her farewell. The patient was well preserved for one of her age, and had been in the habit all her life of being very industrious. I found her in bed surrounded by loving and anxious children and grandchildren. She gaspingly told me she was suffering from heart disease, that it had come on very suddenly about ten days previously and was rapidly getting worse. The patient being greatly excited, I sat by her side and took her hand and gently stroked it a few minutes talking reasonably the while. I then placed my four fingers over the radial artery of the left wrist and counted the beats a full minute. To my surprise they were twenty-two. I again took the pulse in the same wrist to verify my first count. Suspecting an aneurysmal or other tumor I tried the other wrist with the same result—twenty-two beats to the minute.

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* Read before the Orleans Parish Medical Society, November 25, 1899.

Realizing that the pulse was not invariably a true index of the number of systolic contractions, I placed my ear over the heart and found that that viscus contracted forty-four times to the minute, indicating a weakness of the heart muscle rather than any disturbance of innervation. Arythmia was well marked in this case. Three quick beats, followed by a long pause, a pause extending over more time than the three took. Then two quick beats occupying less than half the time the subsequent long pause did. Some of the pauses lasted five seconds and occasionally one would last eight seconds. Time and again I feared the pulse would never return.

Such curious cases of arythmia are called pulsus trigeminus and pulsus bigeminus alternans. Interesting as the pulse was, the most interesting thing to me, the patient and her family was the prognosis.

In the aged, bradycardia is not necessarily of grave import; but bradycardia accompanied by marked arythmia or any cerebral symptoms is of gravest moment.

Our patient had frequent attacks of unconsciousness, sometimes so slight as to be scarcely noticeable and lasting not longer than a second or two. At other times the attacks were much more pronounced and death seemed imminent. To arrive at a correct prognosis, an accurate diagnosis had to be made. An examination of the urine exculpated the kidneys, and there being no evidence of the bradycardia being of toxic origin we were left to decide whether it were of reflex origin, a neurosis or due to disease of the heart itself or the nervous system. Charcot was one of the first to call attention to the connection between injuries of the cervical region of the spine and slow pulse, and as my patient had been thrown violently out of a buggy five years previously and had remained unconscious a number of hours, I thought possibly an injury of the medulla or the cervical portion of the cord had been incurred and that pressure, due to contraction, or the imprisoned vagi, might account for the bradycardia; but modern research has taught us, although the cerebro-spinal nervous system regulates the force and frequency of the heart's beats, its rhythmic action is due to its own automatism. That the cardiac ganglia, imbedded in the muscle itself, regulate the rhythm is believed to have been proven by experiments made on the heart after it had been removed from the body.

After careful thought I came to the conclusion that the bradycardia in this case was due to an atheromatous condition of the coronary arteries, and that the prognosis was hopeless. Treatment gave but temporary relief. Nitroglycerin gr. $\frac{1}{50}$ always gave immediate relief, but the effect seldom lasted over fifteen minutes. Asafetida in five grain pills, every two or three hours, gave marked relief for three or four days. Day by day the patient's pulse got slower. It fell to 20, then to 18, and, finally, to 12, several days before death, which occurred November 4—fifteen days after I first saw her.

I have taken the liberty of reporting this case to you this evening for the purpose of calling attention to the difficulties the most careful of us find in making a proper diagnosis in such cases.

I deeply regret that an autopsy was refused.

Clinical Lectures.

[Specially Reported for the JOURNAL from the Philadelphia Clinics.]

I. AN INTERESTING CASE OF STENOSIS OF THE TRACHEA. II. GOOD RESULTS FROM AN OPERATION FOR EXOPHTHALMIC GOITRE.

BY PROF. W. W. KEEN, M. D.

I bring before you a patient of twenty-one years, operated on five days ago for stenosis of the trachea. She was a patient of Prof. Jones who found the vocal cords normal, but a stricture between and below them. There is a question as to the cause of the condition. There is no history of scarlet fever or other disease that might have easily caused the lesion. The only point bearing on the case at all is that thirteen years ago the patient had an attack of whooping cough. Whether this had anything to do with the condition we found or not I can not say. It is doubtful that this was the cause, but at all events there is no other discernible. Dyspnea became marked about one year ago and finally the obstruction became so serious as to even threaten life. Dilatation was tried but had to be given up. At best this is a long, difficult, and generally unsatisfactory method of treatment. Operation was then determined upon, and I speak of the case as an illustration that such operation can be done without the use of a tracheotomy tube except during the operation.

A linear incision was made in the median line extending from the middle of the thyroid cartilage nearly to the top of the sternum. This long incision was necessary because through it the operation on the stenosis had to be done and also the chloroform given. The anesthetic was given by the mouth and the trachea was laid bare. Then the patient was put in the Trendelenburg position and the trachea divided, the cricoid cartilage as well as the necessary tracheal rings. A tracheotomy tube was then inserted into the lower part of the tracheal incision and into that a tube carrying a rubber tube through which the chloroform was given.

The stenosis extended along the third and fourth tracheal rings and to the upper border of the fifth. An incision was made all the way around, and the mucous membrane dissected back, exposing the fibrous tissue, causing the stenosis. This was cut away and the edges of the mucous membrane brought together and sewed with fine silk. Silk was thought to be the best here, and if the stitches should ulcerate away they will be expectorated and give no trouble.

While operating the wisdom of an open operation, instead of dividing the stricture through the larynx, was considered. In the first place such an expedient would not have relieved the condition in this case. In the second place two arteries were cut, which spurted the length of a finger, and these would have given serious trouble. They were ligated, and then it was seen that a mistake had been made for the bunch made by the ligature and the ends of the arteries to some extent reproduced the stenosis by the projection formed. So they were grasped bv a pair of artery forceps and twisted off, the vessels giving no further trouble. The trachea was then sewed up with catgut and the wound closed by silkworm-gut sutures.

No tracheal tube was left in, and the wound has healed nicely, and the patient can go home on Friday, one week from the day of operation. Had the tube been left in, the time would have been at least three weeks instead of one. A tube is always a bad thing when it is left in. There is always more or less infliction, and the time of recovery is greatly extended. Three days had been devoted to disinfecting the mouth and throat in this case, and no trouble has been experienced since the operation, except a little soreness in swallowing at first, and the temperature has not been above 100 deg. No food was given by the mouth for thirty-six hours. The patient was also kept in the Trendelenburg position, by elevating the foot of the bed, from Friday until Sunday. Some bloody mucous was discharged for twenty-four hours.

I mention the case first, because it is an unusual one, none like it being recorded that I know of, and second, to show the advantage of avoiding the use of the tracheotomy tube. One patient on whom I did a laryngectomy and closed the wound left the hospital in sixteen days and returned to his home in Maine. He also could have left in a week if the length of the journey home had not contra-indicated it.

EXOPHTHALMIC GOITRE.—The patient now before us is one from whom I removed the right part of the thyroid gland, some three months ago. She has been under observation since, and the operation has done her an immense deal of good. Before the operation supra-renal extract was tried for six weeks, without doing the least bit of good. At the time of operation her eyes were protruding, and the pulse was ranging from one hundred and ten to one hundred and twenty. To-day her eyes are normal; temperature is 98.4 deg., and the pulse rate is eighty-two, a diminution of from thirty to forty per minute in less than three months. The only anesthetic used for the operation was cocain for the incision.

THE TREATMENT OF CASES OF PSYCHIC IMPOTENCE.

BY ORVILLE HORWITZ, M. D.

I have two cases of sexual impotency of which I wish to speak. The first patient is a man of thirty-three whose sexual powers were vigorous until two years ago. At that time he had an attack of anterior urethritis which ran the usual course and gave no special trouble. After this, however, there was a complete abeyance of the sexual power. The man became greatly neurasthenic. He had pains in various parts of the body, mental hebetude, fermentative dyspepsia, and nervous alopecia. An examination showed no pathologic condition whatever, except a slight hyperesthesia of the posterior urethra. The man has been under treatment for a couple of months and has very nearly recovered the use of his lost powers.

Here then was a case of impotency without a cause and hence an illustration of pure psychic impotence. The main point in the treatment of these cases is to produce a mental impression upon the patient. Under no circumstances let him know what you think is the cause of his trouble, in other words that there is no cause. Some simple medicine, as harmless pills, should be given for the mental effect caused by its use. Listen with interest and attention to the man's story and gain his confidence, which is the greatest aid in handling such cases. The passing of a cold steel bougie will produce an impression on the mind and may be a slight stimulation of the nerves, though in itself it is really of no use. The physical condition of the patient should be improved as much as possible.

A great mental impression is made by the use of electricity, applied as in case of atonic impotency from early sexual excess, etc. One electrode is carried into the rectum, the bulb resting against the prostate; the other is applied against the perineum by means of a sponge. The current is then passed from the rectum toward the perineum. Two or three milliamperes should be used, but if a current indicator is not used the current should be just strong enough to produce a tingling sensation. This should be applied daily for five minutes at a time at first, gradually increasing to ten. This treatment will be found of service in the class of cases mentioned, as well as in the atonic conditions resulting from other causes.

Society Proceedings.

MEETING OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION, NEW ORLEANS, DECEMBER 5, 6 AND 7, 1899.

Through the courtesy of the St. Charles Hotel management the several sessions of this association were held in the banquet hall of that hostelry.

On the morning of the first day the president, DR. JOSEPH TABER JOHNSON, of Washington, D. C., called the meeting to order.

DR. HENRY DICKSON BRUNS, of New Orleans, delivered a felicitous address of welcome on the part of the local profession, which was followed by an outline of the arrangements of the program by DR. ERNEST LEWIS, who also enumerated the various social functions provided for by his committee of arrangements.

The session at once went into the reading and discussion of papers.

DR. A. M. CARTLEDGE, of Louisville, Ky., read a paper on *Myomatous Tumor of the External Iliac Vein*, presenting the pathologic specimen: "Myomatous tumors arising from the muscular coat of the veins constitute one of the rarest of pathologic curiosities. *Case:* A woman, aged fifty-three years. Five years ago the patient suffered from swelling of the left leg, extending from foot to hip; the swelling subsided in eight or ten months. She had pain at this time in the left iliac region low down. No enlargement was noticed. Two years ago the patient noticed a small lump just above Poupart's ligament on the left side, from which she suffered some pain. Within the last year the pain had been much greater in the left iliac region, and the enlargement more distinct and very hard. Latterly she had been losing much flesh. She had slept poorly on account of pain, and also suffered from accumulations of gas in the bowels. A diagnosis of carcinoma of the deep inguinal glands above Poupart's ligament was made, probably due to some primary, yet undiscoverable carcinomatous lesion in the bowel or uterus. Exploration of the iliac tumor was advised for a more positive diagnosis, and removal if found expedient. The operation was performed on March 9, 1899." A careful relation of the detailed operation was given by the author.

The tumor was removed entire, with not a lobule broken, and passing through it and removed with it were one and three-quarters inches of the external iliac artery, and the same length of the nearly obliterated vein. The only hemorrhage of any account was from the obturator vein, where it passed through the foramen; this was easily secured by ligation. The vessel was much enlarged, as a result of participating in a long established collateral venous circulation. The upper portion of the incision was closed by tier sutures, the lower portion being left open and being occupied by a gauze drain, which was placed down to the obturator foramen. The patient was progressing toward recovery.

Dr. J. Wesley Bovée, of Washington, D. C., read a paper on *Ureterectomy.* The paper considered esssentially the subject of ureterectomy with which the following case was related:

Mr. J. J. T. ——, forty-eight years of age, was first seen in August, 1898. Three years previously his left kidney had been removed for a renal abscess, and subsequently another operation had been done by the same surgeon for the remaining pus tracts and severe localized pain. He had been an invalid constantly before and since the first operation. He had never been without pain, and was frequently obliged to resort to the use of morphin. He was found to be in a very much enfeebled condition, his pulse ranging from 110 to 130, and his temperature from 99 deg. to 101.6 deg. F. On the left anterior and lateral aspect of the abdomen, slightly below the level of the umbilicus, were two scars of the previous operations. A large hernia had occurred at this site. There were three sinus tracts in the left lumber region discharging a thin, watery pus. In spite of the general weakness of the patient an exploration was decided to be advisable, and accordingly on August 17, 1898, after free stimulation, he was anesthetized. A careful exploration was made through an extra-peritoneal incision, reaching from just above the level of the upper fistulous opening and in front of the left quadratus lumborum muscle to an inch inside the anterior superior iliac spine. By careful dissection and holding probes in the fistulæ the former location of the kidney was reached. Instead of the kidney a large amount of adipose tissue, containing many pus tracts and calculi and much cicatricial tissue was found, and a little below it was the upper end of the ureter surrounded by calculi and thickened pus. The ureter was about one inch in diameter and filled with cheesy pus and calculi. It was resolved to remove the duct, and immediately the incision was extended along to the inguinal canal, keeping about one inch from Poupart's ligament. With considerable difficulty, but with very slight loss of blood, the ureter, in pieces, was removed to the bladder wall. The distended lumen ended abruptly about half an inch from the bladder wall, this portion being a solid cord. The wound was closed with through-and-through, silkworm gut sutures, a strip of iodoform gauze being passed to the lowest point of the pelvis wound and brought out at the lower end of the external incision, and another strip in the space formerly occupied by the kidney. The unusual atmospheric high temperature and humidity probably assisted in producing the fatal issue seventeen hours later.

DISCUSSION.—DR. SAMUEL E. MILLIKEN, of Dallas, Texas, called attention to a point in technic adopted by Kelly, viz.: instead of making one incision, he left a bridge of abdominal wall, making the first incision from the twelfth rib down to the crest of the ilium in front of the lumbar muscles, with a second incision along the inguinal region. This enabled the operator to expose the kidney, to make a thorough examination, and also to trace the ureter.

DR. BOVÉE, in reply to Dr. Milliken, said there might be the advantage in two short incisions over one large one, of having a less amount of tissue to cut across, as muscles, fascia, etc., but he thought there was a drawback in having to dissect through a smaller space to loosen the ureter between the two incisions. Such an operation would require more time, which, in many instances, is a precious element. However, he was not disposed to criticise Dr. Kelly's method, because he had never tried it.

DR. W. E. PARKER, of New Orleans, read a paper on *Serious Complications Following Passage of the Urethral Sound*, and reported the case of a man with stricture of the urethra who passed urine with difficulty. The first time a sound was passed he had a chill, with a temperature of 105 deg. F. After a week the sound was passed again, no fever having occurred between the days of passage of the sound. In the meantime he had the man's urine examined, with a report showing the specific gravity to be 1.020, ½ per cent. of albumin, no casts, pus and reaction acid. After the passage of the sound the second time, the man had urethral chill, suppression of urine, and died with uremic convulsions the following day—*i. e.*, the second day after the passage of the sound, although the usual precautions had been taken to prevent urethral chill. The autopsy showed that there was intense congestion of both kidneys, with pus in the pelvis and in the calyces of the left kidney.

Dr. W. P. Nicholson, of Atlanta, Ga., had seen a number of cases of severe chill following the introduction of sounds, in which all the necessary precautions had been taken. He had observed six cases of swelled testicle following the introduction of the sound, but had not seen a fatal case.

Dr. F. W. Parham, of New Orleans, believed that post-mortem examinations would show, in cases in which death had occurred after the passage of the urethral sound or catheter, some form of nephritic trouble, usually the interstitial. He recalled the case of a man upon whom he had operated for strangulated hernia, who had given no history of any renal trouble, yet the patient died of interstitial nephritis, as verified by an autopsy.

Dr, Manning Simons, of Charleston, S. C., said he had met with a number of cases in which the passage of the sound was followed by trouble. It was his routine practice, when a man presented himself for the first time, in whom he had to pass the sound, to administer a grain of opium and ten grains of quinin immediately after its passage to provide against urethral chill and fever. He thought the cases should be divided into three classes: first, those in which the trouble was reflex from the nervous system; second, those in which urethritis was set up by unclean sounds; third, those in which there was serious disease of the kidney, but which was not discovered preceding the use of sounds.

Dr. J. D. Bloom, of New Orleans, narrated two fatal cases from the passage of the sound, which showed post mortem kidney lesions.

Dr. F. W. McRae, of Atlanta, had seen complications follow the introduction of the sound. During the last five or six years he had not introduced a sound, except in emergency, without having the patient under observation for several days thereafter. His results had been better since paying particular attention to careful preparation of the patient and the instruments, repeated examinations of the urine, etc.

Dr. H. H. Grant, of Louisville, Ky., read on *Gunshot Wounds of the Abdomen.* He stated that the surgery of gunshot wounds of the abdomen, which had been for some years pretty well settled to the satisfaction of the profession, received something of a shock by the report of the surgeons who served in the late war with Spain (*Journal of the American Medical Association*, July 11, 1898). The results of the investigation of Klemm showed, in an analysis of one hundred and fifty-two cases, that even those patients in whom penetrating wounds of the abdomen were established, who did not die of immediate effects, eventually nearly all succumbed to exhaustion from sepsis and later suppuration. The meaning of this was that, practically speaking, all cases of penetrating gunshot wounds of the abdomen, untreated by surgical repair of the lesion, resulted fatally, from hemorrhage, peritonitis, or sepsis. The mortality after operations done in the first seven hours after injury was fifty-two per cent., as against sixty-four per cent. for operations at all periods. But a study of the tables of Parker showed such variations in the mortality succeeding complicated and uncomplicated wounds of the various viscera, and all of a fatal character without operation, as to indicate that in uncomplicated wounds in some situations the early operator would save from seventy-five to eighty per cent. of what would otherwise be fatal cases. His tables also showed that of sixteen operations done in which no intraperitoneal injury was found, but three patients died, one from an overlooked perforation and two from peritonitis, due to infected blood clot, a fatal complication upon which Klemm laid much stress. Dr. Grant sent out a circular letter to one hundred prominent surgeons, and an analysis of the reports developed a number of most important and interesting facts. The mortality of the whole number of operation was about 52 per cent., an indication that the prognosis was improving with the more energetic measures of treatment. The practical management of suspected penetrating wounds was as plain a duty as the tying of a bleeding artery, in his opinion. As soon as possible after the injury the patient should be transported to a suitable place, and, under antiseptic precautions, after all preparations have been made for a laparotomy and repair of lesions, the experienced hand should carefully trace the course of the bullet into the cavity, if it went there. This was easy enough when the penetration was direct from the abdominal wall, but was often difficult or impossible when it was from behind or from the thoracic or pelvic cavity. Under these latter circumstances the history of the direction of the projectile, and the general symptoms, must be the only guide, giving to the side of operation the benefit of the doubt.

Dr. H. M. Taylor, of Richmond, Va., said he had operated on three cases of gunshot wounds of the abdomen within the last two or three years, of which one was saved. He laid stress on the utter hopelessness of cases until an operation was done.

Dr. Parker was glad to note that the percentage of recoveries from operative interference in gunshot wounds of the abdomen was improving. Cases occurring in civil life should be operated on as soon as possible.

Dr. Simons had operated on twenty cases of gunshot wounds of the abdomen by laparotomy, and of this number he saved three. One was a gunshot wound of the stomach, the operation having been done within a few hours after the occurrence. There were two perforations, one of entrance and one of exit, the bullet having lodged in the muscles of the back. This patient, a boy, recovered and was well to-day. In one of the cases there were fifteen perforations of the bowel. In some he had resected as much as two feet of the small intestine.

Dr. Milliken had encountered one case of gunshot wound of the abdomen in a child, seven years of age, who had received the contents of a shotgun. He did a laparotomy, and the child recovered.

Dr. Bloom mentioned the case of a man brought to the Charity Hospital, where it was thought the peritoneal cavity had been penetrated, but laparotomy disclosed that there was no penetration. He recalled a number of cases in which the patients recovered when the operation was done within twenty-four to thirty-six hours after being shot.

Dr. Parham said it was difficult in many instances to determine the exact location of the wound in the abdomen; therefore the surgeon should study the character of the wound itself, direction, the distance between the combatants, etc.

Dr. W. E. B. Davis, of Birmingham, Ala., said the question to be settled was whether every case of penetrating wound of the abdomen should be operated upon. He believed every such case should be so treated. The surgeon should examine carefully the wound of entrance so as to determine, if possible, if penetration had taken place. He condemned the Senn gas-test, and said that the teachings of this eminent surgeon in regard to gunshot wounds of the abdomen were harmful, in that they created a sentiment which made it exceedingly difficult in certain communities to operate on cases of penetrating wounds of the abdomen, because, if the patient should die, the surgeon would be censured, and discredit would be cast upon surgery.

Dr. McRae had seen and operated on five cases of gunshot wounds of the abdomen at the Grady Hospital. The point of entrance of the bullet was above the umbilicus, the injury having been received when the patient was standing, and in every one of them there were numerous perforations of the hollow viscera. In military practice, he said, wounds were received by soldiers who had been fasting for a number of hours, and as the intestines were empty extravasation was not so likely to occur. On the other hand, in civil practice wounds were almost always received under conditions of more or less debauchery, when the stomach was loaded with whiskey, beer, food, etc., extravasation of the contents took place rapidly, and death was much more apt to take place. He considered the Senn gas-test worse than useless, it being merely corroborative, not conclusive, as to penetration of the viscera.

Dr. Grant, in closing, said he had enunciated a few surgical principles, and he hoped the members would conclude that it was as much the duty of the surgeon to operate on a penetrating wound of the abdomen as it was in cases of strangulated hernia.

Upon the adjournment of the morning session, the association were entertained at lunch given at the Boston Club by the medical members of that club.

AFTERNOON SESSION.—DR. R. MATAS, of New Orleans, presented *the history of pulmonary insufflation and artificial respiration in intrathoracic surgery by intubation of the larynx.* He exhibited an apparatus, and demonstrated its application, summing up as follows: The original O'Dwyer cannula, while retaining its intralaryngeal portion unchanged, is modified so that it may be utilized, first, as a respirator; second, as a tampon cannula; third, as an anesthetizer; fourth, as a tractor on the tongue; fifth, as an insufflator; sixth, as an aspirator.

DR. LEWIS S. MCMURTRY, of Louisville, Ky., read a paper on *Recto-Vaginal Fistula.* He said that, excluding cancer, recto-vaginal fistula was due to traumatism, not to the compression of the tissue as in vesico-vaginal fistula, but to extensive rupture of the perineum involving the recto-vaginal septum, cicatrizing inferiorily, but leaving a perforation above where the septum was thin and permitted contact of the vaginal and rectal mucous membranes, thus uniting these membranes and making a permanent opening. Wounds made in instrumentation through the vagina, and the pressure of foreign bodies retained in the vagina sufficiently long to produce ulceration and necrosis, were among the rare causes of this lesion. The most common site was in the lower portion of the vagina, just above the sphincter muscles, and at the point already indicated where the septum was thin and the mucous surfaces were in close proximity one to the other. The opening was usually very small, and the mucous membrane was reflected around like a fringe, making its detection more amenable to touch than to sight. The method usually employed in the repair of vesico-vaginal fistula, whereby the edges are freshened in a funnel-shaped denudation, would rarely succeed in repairing a recto-vaginal fistula. The action of the anal sphincter, the penetration of fecal matter, and the sparse layer of tissue, prevented repair by this method. The divulsion of the sphincter muscle would not suffice, in the larger proportion of cases, to overcome this obstacle to success. Extensive cicatricial deposit was another obstacle to repair by this simple procedure. The operation, in consequence, was resolved into a modified perineorrhaphy, by which the fistula was transformed into a complete tear of the perineum. The method of flap-splitting, popularized by the late Mr. Lawson Tait, was pre-eminently applicable to this procedure. By this method broad surfaces were supplied without loss of tissue, permitting gliding of the vagina and rectal orifices of the fistula so as to interpose firm and healthy tissues. In exceptional cases, in which the fistula was so low down as to be within the grasp of the spincter, it would be best to divide the septum vertically, freshening liberally the margins of the fistula, and suturing the surfaces as in complete laceration of the perineum. In a very limited class of cases, in which the fistula was small and the cicatricial deposit was not extensive, a simple denudation and suturing after divulsion of the sphincter ani muscle might succeed. The flap-splitting method already mentioned would be found most applicable, and should be preferred for general application. Vertical division of the septum should be the first step of the operation in low fistula with extensive cicatricial deposit, and the operation was then resolved, after paring the edges of the fistula, into the operation for complete tear of the perineum. It would rarely be necessary to use buried sutures; when used, these should be of catgut, and should be introduced after the Lembert plan. As already stated, the flap-splitting operation of Tait had the greatest field of usefulness in this procedure. The following case was of special interest, both on account of the unique cause of the fistula, and the consequent deduction that a very simple and common gynecologic appliance was not without danger under certain circumstances:

Miss C. W.——, aged thirty-one years, never married, a teacher, was subject to a backward displacement of the uterus. In August, 1899, she applied to a physician for treatment, and a metallic pessary of the Hodge pattern was inserted. The pessary was placed in position on a Thursday by the physician who had referred the case to Dr. McMurtry, and the patient returned to her home, some thirty miles distant from the physician. On the second day the patient began to suffer pain, which increased day by day, and when she was examined by the physician on the Monday following, the pessary was found protruding into the rectum and was removed per anum. When the patient was referred to him on October 6, there was an opening in the recto-vaginal septum just above the anal sphincter, of oval form, that would readily admit the end of the little finger. The operation consisted of divulsion of the sphincter, separation of the vaginal mucous membrane, freshening the edges of the fistula, and suturing with Lembert sutures of catgut the rectal portion of the fistula, gliding and suturing the vaginal mucous membrane. Union was prompt and perfect, and the patient was now quite well.

Dr. C. Jeff Miller, of New Orleans, read the report of an interesting case of *an ossified uterus*, and presented the specimen.

There was no evening session, the members of the association being the guests of Dr. Ernest Lewis, at the old French Opera, where the *Huguenots* was excellently presented on that occasion.

Second Day—Morning Session.—Dr. W. G. Haggard, of Nashville, Tenn., contributed a paper on *the Surgery of Biliary Calculi.* He spoke of the frequent findings of gall stones in the abdominal cavity. After enumerating the usually assigned causes of gall stone, he emphasized the undetermined probability of infection. The continuous pain in inflammatory and suppurative conditions of the biliary passages was contrasted with the intermittent and paroxysmal pain from biliary concretions. In connection with the diagnosis, the fact that jaundice was not essentially a sign of gall stones was emphasized, and waiting for icterus as an evidence of their existence was hurtful. The relatively small number of operations, compared with the frequency of the disease, indicated that the gall stones were either overlooked, or failed to give rise to serious trouble, or that the symptoms were taken for other diseases. The various incisions were described, and the operations of cholecystotomy, cholecystendesis, modified cholecystotomy (without suture), and cholecystectomy were discussed. He said that the surgery of the gall bladder was almost perfected, but the management of calculi in the ducts by various methods was yet unsettled. The various operations on the ducts were discussed, and a case of cholecystostomy for chronic catarrhal cholangitis with gall stones was reported.

In the discussion Dr. McRae narrated a case operated upon a few months ago in which a diagnosis of cholecystitis was made. At the operation an unusual condition of affairs was found. Instead of a distended gall bladder, he found enlargement of the liver, with great distention of a cavity in this organ, hard and nodular to the feel, and occupying this cavity and some small pockets in various directions in the liver were fifty-eight stones, which he exhibited. The adhesions were extensive, but no pus was found.

Dr. J. G. Earnest, of Atlanta, directed attention to the symptom jaundice, saying that it did not appear unless there was obstruction of the common duct. Simple obstruction of the cystic duct did not necessarily produce jaundice. In two or three cases in which he had found the gall bladder filled with inspissated mucus and complete obstruction of the cystic duct, but no obstruction of the common duct, there was no jaundice, while in other instances of common duct obstruction jaundice was present.

Dr. Taylor recalled a case which was diagnosticated at first as cholecystitis. The patient had been jaundiced for six weeks. The abdomen was opened, and on incising the gall bladder and removing a stone from it he found no obstruction of either the cystic or common duct. He did a cholecystostomy and drained the gall bladder, but the patient did not recover. Two months later he reopened the abdomen, and, after a very careful examination, found malignant disease of the head of the pancreas sufficient to press upon the common duct and produce jaundice.

Dr. Simons reported a case in which he removed the whole gall bladder, and said that after a careful search of the literature at his command he could find only twenty cases. The tumor in his case presented just below the ninth rib as large as a goose egg. An exploratory operation was made, and the tumor was found to be the gall bladder. The gall bladder was removed because its walls were greatly thickened and pus had disseminated itself throughout its walls. He believed that if the gall bladder had not been removed at that time, and promptly, there would have been extravasation of pus into the abdominal cavity. Three gall stones were found. There was very little jaundice present.

Dr. Cartledge spoke of the cholemic cases, and said that in the use of the decinormal saline solution, employed either subcutaneously or per rectum, for ten days, two weeks, or in bad cases three weeks, before operative interference, surgeons had one of the most valuable means of overcoming cholemia in patients with gall stones.

Dr. William P. Nicholson, of Atlanta, read a paper on *Inflammation of Meckel's Diverticulum with Resulting Gangrene of the*

Intestine Simulating Appendicitis. He said that the pathologic conditions arising from the diverticulum have been in most cases due to portions of the intestine being entrapped within the encircling cord when the diverticulum had existed in this form; while in some instances there had been an acute inflammation of the pervious tube that had caused adhesions and resulting obstruction. Again the inflammation seemed to have extended to the intestinal tube, causing paresis of the bowel, especially simulating the later stages of appendicitis. In a few cases the symptoms and signs had been so much like inflammation of the appendix that a diagnosis had not been possible. The author reported an interesting and instructive case, and mentioned briefly other cases he had found in consulting the literature. He also reported a case of successful implantation of an artificial testicle.

Dr. T. J. Crofford, of Memphis, reported *two cases of Intraligamentous Cysts:*

Case I.—Miss T———— , aged fifty years, presented herself with an abdominal tumor July 1, 1899. A few days later the abdomen was opened. The tumor was found to be an intraligamentous cyst. Both ovarian arteries were ligated; the uterine artery was ligated upon the healthy side at as low a level as the internal os. The uterus was cut across; the uterine artery was secured upon the tumor side, and the enucleation of the tumor proceeded with. The loss of blood was considerable, although the enucleation was done rapidly. Several arteries in the broad ligament required ligation, and one or two deep down in the pelvis needed to be secured before hemorrhage was under control. The cavity was obliterated as much as possible by suturing together the two layers of the ligament. The woman recovered.

Case II.—Mrs. S———— , aged forty-two years, presented herself with an abdominal tumor October 31, 1899. During the month of June last she experienced an attack of acute peritonitis which came near terminating her life. The acuteness of the attack subsided, but a chronic peritonitis had existed ever since. Abdominal section was made November 6. There were found two tumors, one on each side, developed between the layers of the broad ligaments. The ovarain arteries were secured near the brim of the pelvis. The tumors, which were not of very large size, were separated from the uterus as far down as the operator dared, and the uterine arteries were secured as low as possible after the cysts were emptied. The hemorrhage was alarming at every attempt at enucleation upon all sides. The larger vessels in the broad ligaments and walls of the cysts, several in number, were therefore ligated. The upper portion of the sacs were trimmed off and covered with peritoneum. After the oozing had stopped, the abdomen was closed without drainage. The patient had had an uninterrupted convalescence and had returned to her home.

Dr. Joseph Taber Johnson, of Washington, D. C., then delivered the president's address:

" As the present century is nearing its close our society has rounded out a little more than its first decade of existence. This is the time in the year when our people naturally indulge in reminiscences. The day officially appointed, according to custom and tradition, by the head of the nation, for a national Thanksgiving, has only just passed, and we are rapidly approaching the holiday seasons, when with glad hearts we celebrate, not only the birth of the Saviour of mankind, but the birth of a new year, which is, at the same time, the natal day of a new century. While we have abundant cause for thankfulness over the progress and prosperity of our beloved and united country, during the past century, we have equal cause for gratitude and congratulation over the progress of the science to which we have dedicated our lives. If the pioneers in medicine and surgery could stand upon this platform with me to-day, their glad voices would be raised with more than equal pride and satisfaction, with mine, at the wonderful advances in the ' healing art,' which have been made during the ' twentieth century of medicine,' to which so many of you have contributed. While we glory with the rest of mankind in all that makes our lives and our homes more prosperous, more comfortable and more happy, we take especial pride, as medical men, in the scientific growth of our art as a whole, and in the marvelous development of the particular departments of surgery and gynecology to which this society is especially devoted."

After speaking of the work of country doctors, Dr. Johnson said:

"It was computed some time ago that the perfected operation of ovariotomy alone, since the time of McDowell, has added 100,000 years to the lives of women. Antiseptic surgery can claim almost as much, while anesthesia has robbed all surgery of its pain and made possible many of the marvelous achievements of our profession. When we stop to consider the startling progress in the arts and sciences, even in our own times, who can say what discoveries will be made during the lifetime of many present here to-day, which will give us an antidote for cancer and tuberculosis, yellow fever and cholera, the bubonic plague and general septic peritonitis? We pride ourselves upon the ease and comfort and luxury which the inventions and discoveries of the nineteenth century have brought to us in all departments of labor and of life. The ancient Roman citizen and the ancient courts and emperors felt the same pride. But let us not follow their disastrous examples of contentment, indifference and luxurious idleness. While Nero and his profligate court luxuriated in the results of conquests and the wealth appropriated by their conquering armies, even they little dreamed of the ordinary comforts and cheap conveniences enjoyed by the entire population of our country and of our times. The royal chariots and the fleetest of steeds are now outdone by steam carriers and electric cables; their relays of messengers on horseback by the telegraph and telephone, their torches and bonfires have given place to illuminating gas and electric lights, cold storage has revolutionized certain departments of labor, while the use of the antiseptic principle has done as much for other departments, including the practice of surgery and gynecology. But we can not afford to rest on the accomplishments of the last century, but must continue, unremitted, our efforts until the last great enemy is conquered, as far as human efforts can conquer him.

"The possibilities of liquid air and wireless telegraphy may develop into great aids to the surgeon and gynecologist. One of the great advances made in the recent past is our efforts in the direction of conservative in contradistinction from sacrificial surgery. We believe now that it is a greater triumph of surgery to save a part than it is to sacrifice it. Resection is better than amputation; enucleation redounds more to the reputation of the gynecologist than the radical removal of the parts involved.

More responsibility rests upon him who excises the uterine appendages than upon the surgeon who amputates a leg or an arm. The remote effects of these operations differ very widely so far as the social and domestic happiness of the patient is concerned. The gynecologic surgeon who trains his skill in the direction of eradicating the diseased parts, and leaving one ovary and tube of a portion of the ovarian stroma, in one appendage, does much more for the future happiness and present comfort of women and the fame of surgery than that surgeon does who recklessly and ruthlessly cuts out these important organs, whenever he has opened the abdomen on their account.

"True conservatism versus radicalism will be one of the important problems for the honest workers of the coming century to solve.

"We have much to be grateful for, much cause for felicitation and congratulation, and much to encourage us as we look into the future.

"With the achievements and the memories of the passing century as a stimulus and as an inspiration, let us see to it that the shield of our glorious inheritance is in nowise tarnished by its passage through our hands on to our posterity."

There was no afternoon session, as the association had accepted an invitation to spend the rest of the day on the river as the guests of the Orleans Parish Medical Society.

At 1 o'clock, the steamship Warren presented a charming appearance with her freight of gracious women and noted visitors. This was the first occasion the local profession had had of seeing the social side of their guests. As the steamboat passed the city dock and levees in review, lunch was served to sweet strains of music. The objective point of the excursion was reached duly, and with Mr. Charles A. Farwell as host and guide, the company of the boat was regaled for quite two hours with the intricacies of sugar making on Stanton plantation. On the way home, the galaxy of guests gravitated to the boat's cabin, where toasts were drank, stories told and reminiscences related. At 6 o'clock the landing was made and the association were ready to resume work.

EVENING SESSION.—DR. HUGH M. TAYLOR, of Richmond, Va., read a paper on *Experience in Operations for Typhoid Perforation.* He said it was claimed that one-third of the deaths from typhoid fever were due to perforation. Typhoid perforation was credited with a mortality of 16,660 each year in the United States. The specialist in surgery appreciated what surgery could do and had done in the treatment of typhoid perforations. The general practitioner, into whose hands these cases usually first fell, was not so well informed, and he believed the association should express itself in no uncertain sound. It was claimed, too, that one-fifth of the deaths from typhoid fever were due to hemorrhage. This being so, it would seem just as unsurgical to let a typhoid patient die without an effort to save his life as it would be in the case of profuse hemorrhage from a gastric or duodenal ulcer, or even a ruptured tubal gestation. The author reported five cases, with one recovery from operation. He said less than two hundred cases had now been operated upon. When one recalled the thousands of cases annually occurring, the need for co-operative study was apparent. Nothing short of a moribund condition of the patient should warrant surgeons in abandoning a case as hopeless. The key to success was early operation. More than one-fourth of the cases operated on had been saved by early surgical intervention. He believed that surgeons should be able to save more than 33⅓ per cent. by a timely operation.

Dr. F. W. McRae, of Atlanta, reported *some interesting cases of abdominal surgery.* The first case was one in which he operated for a pancreatic cyst; the second for hepatic calculi; the third for fecal fistulæ; and in the fourth case he did a combined appendectomy and nephrorrhaphy.

Dr. George S. Brown, of Birmingham, Ala., read a paper on Litholapaxy, to appear in full in the Journal. A very limited experience with the operation of litholapaxy had led him to believe that it was being unwisely, although not altogether unreasonably, neglected.

Third Day—Morning Session.—Dr. E. D. Fenner, of New Orleans, reported *fifteen cases of spinal injuries*, treated at the Charity Hospital, in New Orleans (see page 377).

Dr. George H. Noble, of Atlanta, described a *modifiation of an operation for cystocele*, and also reported a case of seventeen years' *congenital nocturnal incontinence of urine*, and one of *pregnancy in a uterus bicornus.*

Dr. I. L. Watkins, of Montgomery, Ala., presented a paper on the *Treatment of Retro-Displacements of the Uterus.*

The following officers were elected: *President*, Dr. A. M. Cartledge, Louisville, Ky.; *Vice Presidents*, Dr. Manning Simons, of Charleston, S. C., and Dr. W. P. Nicholson, of Atlanta, Ga.; *Secretary*, Dr. W. E. B. Davis, of Birmingham, Ala.; *Treasurer*, Dr. W. D. Haggard, Jr., of Nashville, Tenn.

Atlanta, Ga., was selected as the place for holding the next meeting, on the second Tuesday in November, 1900.

MEETING OF THE SOUTHERN MEDICAL COLLEGE ASSOCIATION, NEW ORLEANS, DECEMBER 5, 1899.

The Southern Medical College Association, composed of the colleges south of the Mason and Dixon line and represented at the meetings by one or more members from each faculty, met in annual session in obedience to the rule of the association to meet the first day and in the same place of meeting as the Southern Surgical and Gynecological Association. The colleges present were represented as follows:

Dr. George A. Ketchum, of the Medical College of Alabama, president; Dr. Christopher Tompkins, of the Medical College of Virginia, Richmond, vice president; Dr. G. C. Savage, of the medical department of Vanderbilt University, Nashville, secretary and treasurer; Dr. J. S. Cain, of the medical department of the University of the South, Sewanee; Dr. W. B. Rogers, of the Memphis Medical College; Dr. W. D. Haggard, of the medical department of the University of Tennessee, Nashville; Dr. E. S. Lewis, of Tulane Medical College, New Orleans; Dr. J. D. S. Davis, of the Birmingham Medical College; Dr. T. D. Tompkins, Fort Worth Medical College.

The old officers were re-elected. Outside of this there was nothing of public interest in the meeting, which was devoted entirely to routine matters, the success of the association along the lines on which it was established having left almost nothing to be done at this meeting.

Others present in connection with the business of the association were Drs. Rhett Goode, of Mobile; G. C. Savage, of Nashville; G. H. Simmonds, of Chicago, and R. B. Granger, of New York.

N. O. Medical and Surgical Journal.

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

THE NEW YEAR.

The advent of a new year causes one not only to peer into the future, but to look back and study the past; particularly is this likely to be so when the year in question is to close the century.

A reminiscent mood thus engendered, what more natural than for the editors of the JOURNAL to recall some of the past history of this publication which has existed during more than half of the closing century? Its initial number was that for May, 1844, and it was the first medical journal published south of Louisville. To quote from its introductory address, "few, very few physicians in the South had ever offered contributions to medical literature" at that time. It became at once the aim of the JOURNAL to arouse the local men, and to give a fresh impulse to medical study and investigation. Through a long career and through many vicissitudes the same object has been kept in view and, we believe, with a fair measure of success.

For 1900 we can only continue to stimulate the pursuit of investigation, the recording of thoughts and observations on the part of our confrères of the South, and the publication of such, through us, to the profession of the entire country and the world.

We wish all of our patrons health and happiness for the coming year, and can announce no better platform than a few words quoted from our first number in 1844: "Our JOURNAL shall be liberal, independent and impartial. * * * It is subservient to no personal, no party interest. We pursue a higher and a nobler aim—the cultivation of medical science and the improvement of its followers."

NATIONAL MEDICAL LEGISLATION.

The American Medical Association, through its legislative committee, has taken steps to obtain the co-operation of the several State Medical Societies, whereby each may send two delegates to Washington in January or February to urge upon Congress legislation of importance to the profession. Among the matters to be brought up are the establishment of a public health department, provision for a general license to physicians to practice anywhere in the United States, and a request for an appropriation for the publication of an Index Medicus.

This is a step toward the better recognition of the medical profession in this country, and it behooves each and every State Medical Society to see to it that the delegates are duly sent to Washington. But this is not all. Representatives in the two divisions of Congress should be educated to the necessity for legislation for medical advance. This must be done by the rank and file of the profession, and now. No better influence can be brought to bear upon a public official than that urged by the disinterested, when a disinterested motive is evident.

Already memorials and messages have been sent, with due style and punctiliousness, by medical men of all sorts and of all kinds of organizations, but without result, because the vast body of medical men at home customarily leave the matter to hatch without supplying the necessary stimulus from time to time.

This time the project comes from the representative body of medicine in the United States, carrying with it the weight of opinion of thousands of physicians, who only ask for what at a glance is seen to be primarily for the public good, while only by secondary reflection it helps the medical man himself.

We may have our individual views as to what the function of a health department at Washington should be; we may doubt the practicability of a national medical practice act, but the spirit of the thing appeals to us as correct, and the outcome must be just as what we, as citizens and as medical men, shall make it.

THE AFTERMATH.

Every practicing physician in New Orleans has received a circular of questions from the Citizens' Protective Association purporting to be directed at a remedy for the disastrous quarantines with which New Orleans has been afflicted for the past three years.

The questions deal with some phases of the characteristics of yellow fever, and they are intelligent as a whole.

We do not believe that the question of the future is to be met by any such statistic inquiry. In the first place, only a part of the profession in New Orleans will answer the questions; secondly, the majority of the profession will not answer all of the questions, and thirdly, the questions which are answered will not be answered with any degree of uniformity so as to formulate a basis of action.

After three years of abuse of medical men, attacking their honesty of opinion and their ability and judgment, the commercial bodies of the city at least acknowledge that only from the medical standpoint can the question be met and handled. This is as it should be, and with that acknowledgment, the past should be buried and left out of consideration.

That some procedure should be adopted by which a better enlightenment of people should come about is certain, and this should be found.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans

Some Further Remarks on Anesthesia by Spinal Injections.—We have already reported in this department the clinical experience of Bier and of Seldowitsch in anesthesia produced with minute doses of cocain introduced by lumbar puncture. We copy from the *Philadelphia Medical Journal* of December 16, 1899, the following note, which is interesting as showing that the French are also taking it up:

"Our special correspondent from Paris writes us that Prof.

Tuffier, surgeon to the Hospital Lariboisière, has just communicated to the *Société de Biologie* the results of his experiments upon surgical analgesia from the spinal subarachnoid injections of between one and two centigrams (one-sixth to one-third grain of cocain dissolved in one or two *c. c.* of sterilized artificial serum). The injection was made as in lumbar puncture, and in ten minutes after there was complete surgical analgesia of the inferior extremities. The following operations have been performed under the influence of this cocain injection: Resection at the tibio-tarsal articulation, duration of the operation 40 minutes; trephining of the tibia, duration of the analgesia 30 minutes; resection of the knee, 40 minutes duration; fracture of the thigh. In the last case the analgesia extended to the umbilicus nine minutes after the injection and lasted over one hour. Other cases were: Pirogoff amputation lasting 40 minutes; amputation of the hip joint and extirpation of the inguinal glands, 35 minutes; resection of the knee, duration of the operation 50 minutes. In some of these cases the return of the parts to their normal sensibility was followed by intense headache and vomiting, but aside from this there were no other effects observable, and the cases went on to an uneventful recovery."

THE SIMPLEST AND MOST USEFUL ANASTOMOSIS FORCEPS.—Andrew J. Downes, in the *Philadelphia Medical Journal* for December 16, 1899, again describes the forceps devised independently by himself and Genella, of New Orleans. The present article is well illustrated, showing clearly the technic of the method of intestinal suture with the aid of this instrument. He has altered the length of the forceps and has given them a better spring and catch. As now made it is a practical and useful instrument for other purposes than that for which it was intended. "It is an excellent sponge-holder, and as such I now constantly use it. It makes a good cyst-forceps and tongue-tractor, and will be found a serviceable hemostatic forceps, especially for broad, oozing surfaces deep in the pelvis." Two sizes for the adult and one for children will be all that can be required, since a small one may be used to unite a large bowel and a large size may be used to unite a bowel of less size than its own. It must be remembered that the bowel is distensible, and that after the introduction of the fixation sutures even the colon-size forceps can be introduced and used within the small bowel. Downes has demonstrated that his forceps can be withdrawn without rotating the handles at all, by simply holding the forceps firmly and pushing the unclamped bowel off into the hollow of the blade. He seems entitled to the credit of having devised and demonstrated a forceps made upon perfectly circular fenestrated rings, with a small segment left open for introduction and removal as a whole. This is no inconsiderable advantage in an operation in which every moment of time saved is of importance. These forceps are worthy of a trial by every surgeon who does any abdominal work. If every surgeon can do what is claimed for them by Dr. Downes, no operator will afford to leave them out of his surgical kit.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller,
New Orleans, La.

Fifty Cases of Eclampsia.—Joseph Boyer (*Monats. für Geb. und Gyn*, July, 1899) states that in a series of 4250 births fifty cases of eclampsia were observed, a proportion of one in eighty-five cases. In every case albumin was present in the urine. The eclampsia occurred in ten cases ante-partum, of which six died; in labor, in twenty-nine cases, with a mortality of six; in eleven cases post-partum, all of which recovered. Of the fifty-six children, thirteen were born dead, twelve died on the first day and thirty-one left the hospital alive. Boyer seems to place the greatest reliance on morphia as a theurapeutic agent. He claims that it prevents the onset of convulsions; its effect was most apparent in the post-partum cases, for in none of these did convulsions occur after its employment. He agrees with Veil in recommending larger doses of morphia, as in ordinary doses no effect is obtained. In many of his cases he noted morphinism on the children when born, paralysis of the muscles of respiration and slow action of the heart, which were overcome by persistent efforts at artificial respiration. The effects of morphia on the children were no more marked than those produced by chloroform where surgical anesthesia had been prolonged in order to permit of an obstetric operation to effect delivery.

Chloral administered by enema, while a valuable drug, is too uncertain in its effects on account of the frequency with which the whole or part of the enema is expelled. After a few trials it was abandoned. Diaphoresis obtained by means of hot baths followed by hot packs, Boyer considers, gives the most satisfactory results. The convulsions diminish in frequency and intensity, cyanosis disappeared, and frequently the patient regained consciousness. Labor was accelerated, as the treatment seemed to favor dilitation of the os and increase the effectiveness of the uterine contractions so that spontaneous delivery resulted, or at least an early recourse to forceps was rendered possible.

Venesection was resorted to in seven cases, of which four died. The mistake of waiting until all other measures failed before employing it accounts for the number of deaths. In two cases, where early venesection was done and salt solution infused, the most brilliant results were obtained. Bleeding, Boyer believes, permits the withdrawal of the toxins, and the salt solution introduced dilutes the retained toxins and blood.

Of the 39 cases where the convulsions occurred either before or during labor, 10 delivered spontaneously with only one death. In three cases Cesarian section was performed in the moribund state with the hope of saving the children, but without success. In the remaining 26 cases operative measures were necessary to effect delivery, resulting in a mortality of 8 mothers. Thus Boyer notes that forcible delivery distinctly increases the maternal mortality as contrasted with cases where the delivery is left to nature. On the other hand, it was apparent that emptying the uterus had a beneficial effect on the intensity and frequency of the convulsions. In 21 cases they did not recur, in 13 cases their recurrence was diminished, and in 2 cases the convulsions were not affected by delivery. Forceps were applied in 11 cases, with 3 maternal deaths. In all 3 convulsions persisted after delivery. In 10 cases deep incisions of the cervix were resorted to, with 4 deaths; 8 of these were delivered by forceps and 2 by turning.—*Montreal Medical Journal*, Nov., 1899.

PERINEO-VAGINAL INCISION FOR THREATENED RUPTURE OF THE PERINEUM, according to L. A. Frietsche (*Northwestern Lancet*, September, 1899), is indicated:

1. In stenosis of the vagina due to cicatricial contraction following the ulcerative processes of syphilis and infectious diseases and lacerations from previous parturitions.

2. In high forceps operations or version in primiparas where haste is demanded and the presenting part has not time to dilate the muscular ring of the pelvic outlet.

4. In occipito-posterior positions, when the occiput rotates into the sacral cavity.

5. In narrowing of the pelvic outlet, as in funnel-shaped or kyphotic pelvis, and when the transverse diameter is not narrower than 8 *cm.*

The following method is advised: With angular scissors or a scalpel cut into the introitus on one or both sides, at the beginning or end of a labor pain, in the direction of a point midway between the rectum and the tuber ischii, a little nearer to the latter. The length of the incision into the vagina should be 4 *cm.*, and the depth given by the incision through the skin about 3 *cm.* The head and shoulders will act as tampons and prevent hemorrhage. As soon as the child is born bleeding will be arrested by sutures which bring the cut surfaces in apposition. In consequence of the retraction of the muscles the contour of the wounds is changed and care is necessary to approximate the surfaces properly. If this is not done there may result elongation of the vulva, or an artificial drawing out of the posterior vaginal wall. Iodoform or boric acid is dusted over and a strip of gauze laid in the vagina and made to cover the outer part of the wound. In some cases the incisions must be deeper, and again, in others, a simple incision will overcome the obstruction. The scars are very insignificant. Laceration and sepsis may often be avoided in this way. The patient must be kept on her back for twelve or fourteen days.

HEART DISEASE, FROM AN OBSTETRIC POINT OF VIEW, is briefly summarized as follows:

1. A woman having a heart lesion which is compensated should not be prevented from marrying.

2. Abortion should not be induced on a woman with disease unless very serious symptoms are present.

3. Premature labor should seldom or never be induced on account of heart disease.

4. Mitral stenosis is the most serious heart lesion during pregnancy and labor—aortic stenosis comes next—then probably aortic incompetency. Mitral insufficiency is the least serious lesion.

5. Treatment during pregnancy. Administer the following according to indications: Strychnin, digitalis (or strophanthus), cathartics, nitrite of amyl, nitro-glycerin, and regulate the diet.

6. Treatment during labor, keep up the action of digitalis (or strophanthus) especially during first stage. Give strychnin and stimulants if required and chloroform. As soon as the first stage is completed deliver with forceps.

7. Watch the patient carefully during the third stage (the most dangerous time) and for some days after.

—WRIGHT, *Am. Med. Quarterly.*

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

SCHOOL HYGIENE.—To open this important subject for general discussion before the Medical Society of Virginia, October 24, 27, 1899, the following papers were read:

1. *How best, in every way, to promote the health of our children in the public schools*, by J. H. Neff, M. D., Harrisonburg, Va.

The concern for bodily health, which is almost entirely neglected while the process of leading out the whole mind goes on, demands the best thoughts and hearty co-operation of the whole community, the placing of competent men in authority; the running of the machine in order, the constant desire of improving it along all lines, taking thought for all its objects in order.

2. *Hygiene of the School Room*, by Hugh McGuire, M. D., Alexandria, Va.

Study hours should be properly arranged and not too long. A child's mind should not be too constantly employed. Rest of two hours for dinner between the morning and afternoon sessions should be allowed. The younger children should only attend the morning session, and even then should be allowed fifteen or twenty minutes rest every hour or so. Disapproval of requiring school children to do home study besides their school work. The sewerages of a school should be perfect, the closets scrupulously clean. The drinking water pure, kept out of the atmosphere of the school room. The school room should be furnished as simply as comfort will permit. Good light in the school room is a necessity, also the proper heating and ventilation; the amount of fresh air for each child in the room should be measured; 2500 cubic feet of fresh air must be supplied for each child every hour. Children should not be allowed to enter the public schools until they have undergone a physical examination by a competent physician.

3. *Care of the Eyes of School Children*, by A. C. Palmer, M. D., Richmond, Va.—Errors in refraction and other defects exist to an alarming extent in our public schools, and if left uncared for, disastrous consequences result. Great difficulties are in the way of affording protection to these innocent children. Lack of co-operation is the great obstacle to be overcome. Lack of appreciation on the part of the parents. Authority will not face the question of expense. The necessity for a great reform in this direction must be apparent to every humane member of society on the ground of simple justice. Germany sets a splendid example to follow in the case of the eyes of school children.

4. *Adapt Studies, etc., to Conditions*, by John Herbert Claiborne, A. M., M. D., Petersburg, Va.

Some of the text-books seem hardly suited to purposes of rational education. In glancing over an arithmetic the author noted a number of sums propounded for a class of beginners, not one of whom was over 12 years, and these problems could be solved only with the aid of algebra. Overwork and overstrain are but two of the many evils which are attached to the present system of schools, and which enervate and emasculate so many excellent scholars and send them into the world utterly unfitted to do its battles or to fill the duties of life in any department.

What is the remedy?

The public school can be reached and its abuses corrected by wise and judicious appointees, and the appointee is always under the surveillance of the citizen, who makes the State. Abuses, therefore, can be reached and corrected in the public schools, and when the citizen awakens to his duty in this matter, such abuses need no longer to exist.

5. *School Room Diseases*, by Frederick Horner, M. D., Marshall, Va., Past Assistant Surgeon (retired) U. S. Navy.

Eye Diseases, especially *Shortsightedness*. Among the chief causes Dr. Cohn considers the construction of the desks and chairs one of them, and the manner in which school rooms are generally lighted.

Headache, *Bleeding from the Nose* and *Goitre* (scholar's goitre of Guillaume), resulting from congestion of the cerebral circulation.

Spinal Diseases, chiefly *Scoliosis*.

Diseases of the Respiratory Organs. Consumption in connection with scrofula. Chief cause traced to vitiated air by reason of so many children being crowded together in one room, and by the change from the hot school room to the cold outside air, dust in the school room and impaired respiratory movements produced by continued sitting.

Diseases of Organs of Digestion. Due chiefly to lack of ventilation and exercise; also to excess of mental work.

Diseases of Organs of Generation. The necessity of having experienced ladies as teachers in girls' schools should not be overlooked where circumstances during the period of puberty imposes upon the teacher an exceedingly difficult task, and also where dangers of bad example, long continued sitting, and mental excitement are ever present.

Finally, *Contagious Diseases*.

Summing up, the chief causes are;

(1) The air of the school room, the condition of which is dependent on the size of the room, the number of the pupils, the heating arrangements, ventilation, dampness of the floor and walls, and dust.

(2) The light of the school room, dependent on the location of the building and the room, size of the windows, color of the walls, artificial means of lighting—whether of gas or oil—the arrangements for sitting, the length of time scholars are obliged to sit still in one position, bodily exercise, such as out-

door games, etc., mental exercises, extent and manner in which they follow each other, and the determination of the individual habits of the pupils of schools and colleges, whether addicted to the habitual use of tobacco or ardent spirits, either acquired or inherited.—*Virginia Medical Semi-Monthly*, November 10, 1899.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans, La.

Nirvanin, the hydrochlorate of the di-ethyl-glycocoll-p-amido-o-oxy-benzoic-acid-methyl-ester, has been made the subject of examination by Joanin, which has shown that nirvanin is less toxic than all the other drugs recommended for local anesthesia. Only the eucain B, made by the firm of Schering, most closely approaches nirvanin in this respect. When injected intraperitoneally in warm-blooded animals, nirvanin causes, provided the dose of 65 cgm. for each kilogram of the body weight is not exceeded, simply increased reflexed excitability; only large doses give rise to spasmodic symptoms, which may become fatal when 70 cgm. is exceeded.—*Notes on New Remedies.*

Mutase and Plasmon.—The former, according to E. Koch (*Centralbl. f. innere Med.*), is a preparation rich in albumin, which is made from food plants, freed as much as possible from cellulose and starch. It forms an almost tasteless yellowish powder and dissolves partly in cold water. Mutase contains 58.27 per cent. albumin, 21.6 per cent. of non-nitrogenous extractives, 9.65 per cent. of salts (among which are 2.5 per cent. of phosphoric acid and 0.35 per cent. of ferric oxide), and 9.85 per cent. of water. About half the albuminous substances dissolve in water; when the solution is heated only a small portion coagulates. The preparation does not irritate the intestine and is rapidly absorbed. The same claims are made for plasmon, which is a new albuminous preparation obtained from milk. The method of manufacture is that of Siebold: skim milk casein is mixed with just enough sodium bicarbonate for its solution, then is kneaded warm by machinery and is finally comminuted.

The finished product forms a yellowish powder, free from odor and taste, and completely soluble in warm water. According to W. Prausnitz (*Münchener Med. Wochenschr.*) plasmon contains 13 per cent. of nitrogen and 8 per cent. of ash; it may take the place of meat and is absorbed with facility, as shown by the small amount in the feces. Siebold's albuminous preparations, unless the price prevents, might possibly compete with tropon, which is a pure albumin obtained from animal and vegetable sources. One kilogram of tropon is said to possess the nutritive value of 5 kgm. of beef or of 180 to 200 eggs. One defect of the preparation is its insolubility in aqueous fluids.—*Notes on New Remedies.*

ASPIRIN is a combination of acetic and salicylic acids. It crystallizes in white needles, melts at 135 deg. C., and dissolves with difficulty in water, but readily in alkalies which soon split it up into its components, salicylic and acetic acids; this fact warrants the conclusion that it will undergo an analogous decomposition in the body under the influence of the alkaline juices. It is said to be very effective in rheumatic affections, in which doses of from 4 to 5 gm. per day may be employed. An advantage claimed for the preparation is that tinnitus aurium is much less apt to occur than after the use of sodium salicylate.

THYMOL CARBONATE.—According to Pool (*Nederl. Tijdschr. v. Pharm.*), by conducting phosogen gas into a solution of thymol in a 20 per cent. soda lye we obtain a thymol carbonate which is not solid, but a light yellow syrupy liquid that has the advantage over thymol of being almost tasteless. According to Pool, the preparation is likely to pass through the stomach without being decomposed, so that we may expect the nausea often following the ingestion of free thymol may be avoided by the exhibition of the carbonate. The preparation is insoluble in water and is not decomposed by an aqueous solution of caustic soda, but an alcoholic solution of soda reduces it, there being formed sodium carbonate and sodium thymolide.—*Notes on New Remedies.*

PERSONS WHO SHOULD NOT TAKE ALCOHOL.—According to Dr. Clouston, the use of alcohol should be forbidden to all persons:

1. Who have any family history of drunkenness, insanity, or nervous disease.
2. Who have used alcohol to excess in childhood or youth.
3. Who are nervous, irritable, or badly nourished.
4. Who suffer from injuries to the head, gross diseases of the brain, and sunstroke.
5. Who suffer from great bodily weakness, particularly during convalescence from exhausting diseases.
6. Who are engaged in exciting or exhausting employments in bad air and surroundings in workshops and mines.
7. Who are solitary and lonely, and require amusement.
8. Who have little self-control, either hereditary or acquired.
9. Who suffer from brain weakness, the result of senile degeneration.—*The Practitioner.*

How to Avoid Consumption.—*The New York Medical Record* gives these nine concise rules for avoiding tuberculosis:

1. A generous dietary of nitrogenous food.
2. Free ventilation of dwelling and sleeping rooms, by open windows, with wire gauze blind.
3. Adequate house-heating in winter.
4. Boil all milk or cream previous to using.
5. Obtain eight hours' sleep; if not sound sleep, contract hours to seven and rest during the day.
6. If debilitated with weak digestion, rest in a recumbent position shortly before and after meals.
7. Wear loose clothing, especially around the waist and lower ribs, to afford freedom in respiration.
8. Take systematic daily exercise in the open air on foot.
9. If means and station in life admit of a long holiday, from time to time, live during fine weather in a tent in the open air, or in summer house for most of the day, and, if unemployed, pursue a hobby to occupy the mind.—*The International Journal of Pneuma-Therapy.*

Treatment of Chronic Morphinism.—H. A. Pressey, in the *Journal of the American Medical Association* of August 12, 1899, says that the sudden withdrawal of morphin, according to the method of Levenstein, is barbarous, and he thinks no patient who had a previous knowledge of the suffering which he would endure where this method is followed would ever place himself under treatment. Modifications, as prescribed and followed by others who withdraw the morphin gradually, but yet have minimized the dose in advance of restoration of the nervous system, are almost equally severe. Erlinmeyer is of the opinion that the suffering in these cases is quite equal to those in which the drug has been suddenly withdrawn. Pressey thinks that this is true with a fixed rule for reducing the morphin, but it is not true if the reduction in the amount is made only to such a degree as is warranted by the improved condition of the patient. He claims that in 90 per cent. of the cases it is possible, by restoring the system to its normal condition in advance of withdrawing the morphin, that each successive reduction is not noted by the patient. He never withdraws the fraction of a grain until the dose is so small that the patient is unable to tell when he took his last dose. The key to the situation is to keep the patient on just as small a quantity as is compatible with comparative comfort. He gives the morphin four times a day, at 7 A. M., 12 M., 5 P M. and 9 P. M. The time is divided in this manner so as to administer the drug before meals and at bed time. Under this arrangement the majority of cases improve in weight during the stage of withdrawal, and an occasional patient will say he feels better during the treatment than while taking the morphin in larger doses than was needed. The writer has found the following prescription useful in sustaining the nervous system during a withdrawal:

℞ Strychnin	$\frac{1}{4}$ grain.
Hydrastin hydrochlor	6 grains.
Spartein sulph	3 grains.
Atropin sulph	$\frac{1}{6}$ grain.
Aquæ	1 ounce.

Twenty minims hypodermically four times a day at the same time morphin is given.

In conclusion, he says that no class of patients require so much personal attention as those under treatment for the morphin habit. He does not believe in any fixed form of medication, but each case should be studied in reference to its own needs. Baths and massage are beneficial in many cases. A hot bath at bed time will sometimes secure sleep, while in others dry heat is more beneficial. The patient should take little or no exercise.—*Medicine.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King,
New Orleans.

A New Treatment for Chronic Catarrhal Inflammation.—Professor Grazzi, of Florence, has instituted a new and simple mechanical treatment in certain forms of chronic pharayngitis, with which he claims to produce most favorable results. The instrument he employs consists of a small polished metallic wheel or roller attached within the fork of a metallic handle and set at an angle to permit of its being easily applied to the pharyngeal wall. With this little instrument the pharyngeal wall is subjected to a kind of massage or compression, the roller being made to pass over the mucosa from the above downward and moderate pressure exerted upon it. The author applies the treatment to those forms of chronic pharyngeal inflammations characterized by a hyperplasia of the lymphatic tissues and thickening of the mucous membrane, and his theory is that this action of compression promotes absorption of the hyperplastic elements and activates the lymphatic and sanguineous circulation of the parts. Under the influence of this treatment, the pharyngeal granulations rapidly disappear and the mucous membrane assumes a more normal aspect. Local anesthesia may be required in the beginning of the treatment to overcome the reflex irritability of the pharynx.—*Annales des Maladies d'Oreille, du Larynx, etc.*

A Case of Vicarious Menstruation from The Ear.—Lermoyez, of Paris, has recently published a minutely detailed history of such a case which has been under his observation for more than three years. The subject was a young girl 17 years of age who for three years had been having regular monthly discharges of blood from the right ear lasting three or four days and accompanied by all the phenomena associated with the menstrual periods. Patient suffered with headache, somnolence, malaise and slight tenderness about the ear at each recurrence of the hemorrhage, these symptoms disappearing upon its cessation. Examination of the ear revealed a perfectly normal tympanic membrane, but a number of small varicose vessels occupied the walls of the osseous portion of the meatus and was the seat of the hemorrhage. The genital menstruation appeared at the age of 17 years, but the discharge from the ear, instead of ceasing, accompanied the vaginal flow and in addition was at times associated with epistaxis and hemorrhage from the mouth. The patient was in good general health and presented no evidence of being haemophilic or hysteric. The hearing was not materially affected. Menstruation from the ear is an extremely rare condition and but few similar cases have ever been reported.

TUBERCULOUS PERFORATIONS OF THE SOFT PALATE.—This uncommon lesion was described, some months ago, by Du Castel, who made known the fact that only one case of similar nature had been reported in medical literature. More recently, Grossard related the histories of two cases coming under his observation, where extensive perforations of the velum palati showed convincing evidence of being of tuberculous origin. In both cases there existed tuberculous implication of the lungs, and in both a rigid anti-syphilitic treatment had not the slightest effect. A remarkable feature was the rapidity with which the destruction of tissue occurred and its resistance to all local and constitutional treatment. In one case ulceration in the pharynx and the nose were also present.—*Archives Internationales de Laryngologie.*

A CASE OF TUMOR OF THE MEDULLA CAUSING DEAFNESS.—The case is one reported by Gray, of Glasgow, at the recent congress of otology, of London. A man, 22 years of age, with an excellent hereditary history, and no specific infection, became affected with deafness in the left ear and a facial paralysis of the same side, accompanied by vertigo and difficult deglution. Speech was affected as a result of paralysis of the left side of the palate, tongue and mouth. Loss of taste on left half of tongue, motor paralysis of left side of body and loss of sensation of right. A test of hearing showed the auditory nerve on the left side to be affected so that a watch could be heard only on contact with the auricle. Death occurred at the end of seven weeks, and an autopsy revealed a tumor involving the left half of the medulla and floor of the fourth ventricle. The nerve tissue was swollen, soft, and of a yellowish color, with hemorrhagic effusions. Under the microscope the neoplasm proved to be a glio-sarcoma.

Medical News Items.

The Thirteenth International Medical Congress will be held in Paris, August 2 to 9, 1900. The American National Committee of the International Medical Congress has been organized, with Dr. William Osler, of Baltimore, as chairman, and Dr. Henry Barton Jacobs, of Baltimore, as secretary.

All Doctors of Medicine are entitled to membership in this Congress by making the proper application and paying the sum of $5. The secretary-general in Paris has instructed the American National Committee to receive the applications of American physicians, and for this purpose a blank form may be had of the secretary, upon which is to be written the full name and address, degrees, and any position of note held, together with the section of the Congress to which the writer wishes to belong. A visiting card should also be appended. These forms, with the $5, are to be returned to the secretary of the National Committee, at 3 West Franklin street, Baltimore. He in turn will send receipt and forward the slips and money to Paris, where they will be registered, and in due course of time a card of admission to the Congress mailed to each applicant.

The committee hopes the American representation in this extremely important Medical Congress may be as large as possible, and they urge every member of the profession to enter his name for membership, this alone entitling him to receive a digest of the full proceedings of the Congress and the printed report of the section to which he belongs. Communications respecting the delivery of these reports to members to be addressed to M. Masson, publisher of the proceedings of the Congress, 120, boulevard St-Germain, Paris.

The sections are as follows:

Class I—BIOLOGIC SCIENCES.—A. Section of Descriptive and Comparative Anatomy.—*Secretary:* M. Auguste Petit, 60, rue Saint André-des-Arts, Paris.

B. Section of Histology and Embryology.—*Secretaries:* MM. Retterer and Loisel, 15, rue de l'École-de-Médicine, Paris.

C. Section of Physiology and Biologic Physics and Chemistry.—*Secretary:* M. Dastre, à la Sorbonne, Paris.

Class II—MEDICAL SCIENCES.—A. Section of General Pathology and Experimental Pathology.—*Secretaries:* M. Charrin, 11, avenue de l'Opera, Paris, and M. Roger, 4, rue Perrault, Paris.

B. Section of Bacteriology and Parasitology.—*Secretary:* M. R. Blanchard, 226, boulevard Saint Germain, Paris.

C. Section of Pathologic Anatomy.—*Secretary:* M. Letulle, 7, rue de Magdebourg, Paris.

D. Section of Internal Pathology (General Medicine).—*Secretaries:* M. Rendu, 28, rue de l'Université, Paris, and M. Widal, 155, boulevard Haussmann, Paris.

E. Section of Medicine of Infancy (Diseases of Children).—*Secretary:* M. Marfan, 30, rue La Boëtie, Paris.

F. Section of Therapeutics, Pharmacology and Materia Medica.—*Secretary:* M. Gilbert, 27, rue de Rome, Paris.

G. Section of Neurology.—*Secretarg:* M. P. Marie, 3, rue Chambacérès, Paris.

H. Section of Psychiatry.—*Secretary:* M. Ant. Ritti, Asile de Charenton, Seine, France.

I. Section of Dermatology and Syphilography.—*Secretary:* M. G. Thibierge, 7, rue de Surènes, Paris.

Class III—SURGICAL SCIENCES.—A. Section of General Surgery—*Secretary:* M. Walther, 21, boulevard Haussmann, Paris.

B. Section of Surgery of Infancy.—*Secretaries:* M. A. Broca, 5, rue de l'Université, Paris, and M. Villemin, 58, rue Notre-Dame-des-Champs, Paris.

C. Section of Urinary Surgery.—*Secretary:* M. Desnos, 31, rue de Rome, Paris.

D. Section of Ophthalmology.—*Secretary:* M. Parent, 26. avenue de l' Opéra, Paris.

E. Section of Larynology and Rhinology.—*Secretary:* M. Lermoyez, 20 bis, rue La Boëtie, Paris.

F. Section of Otology.—*Secretary:* M. Castex, 30, avenue de Messine, Paris.

G. Section of Stomatology.—*Secretary:* M. Ferrier, 39, rue Boissy-d'Anglas, Paris.

Class IV.—OBSTETRICS AND GYNECOLOGY.—A. Section of Obstetrics.—*Secretaries:* M. A. Bar, 122, rue La Boëtie, Paris, and M. Champetier de Ribes, 28, rue de l'Université, Paris.

B. Section of Gynecology.—*Secretary:* M. Hartmann, 4, place Malesherbes, Paris.

Class V.—PUBLIC MEDICINE.—A. Section of Legal Medicine. —*Secretary:* M. Motet, 161, rue de Charonne, Paris.

B. Section of Military Surgery and Medicine.—*Secretary:* M. Chatteau, Ministère de la Guerre, Paris.

Members desiring to present papers will forward the title and a résumé before May 1, 1900, to the Secretary of the Section to which they belong, for each Sectional Committee reserves to itself the right of drawing up its own working program. Papers are limited to fifteen minutes.

THE FOURTH INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILIS will be held in Paris, August 2 to 9, 1900. The sessions will be carried on at the St. Louis Hospital, at the same time as the International Medical Congress, with which it will be combined in the section on the same subjects. A preliminary program has issued, giving the subjects for general discussion:

Dermatology—1. The Parasitic Origin of Eczema; 2. The Tuberculides; 3. The Ringworms; 4. Leukoplasia.

Syphilis and Venereology—1. Syphilis and Allied Affections; 2. Transmission in the Hereditary Syphilitic; 3. Causes of Generalized Infections in Blenorrhagia.

Members of this Congress are considered as members of the general Congress, and the one fee of $5 is inclusive of both if sent to the Secretary General, M. le Docteur Georges Thibierge, 7 rue de Surène, Paris, or to Secretary for the United States, Dr. George T. Elliot, 36 East 35th street, New York City.

CONGRESS ON "TUBERCULOSIS AND ITS MODERN TREATMENT." —It has been decided by the management of the New York Medico-Legal Society, to devote an extraordinary session to "Studies on Tuberculosis, its Management and Modern Treatment," on the third Wednesday of February, 1900, to open a full investigation and discussion of the whole subject, and to invite the leading American scientisst and specialists to contribute papers, and unite in the discussion of this subject, and the most advanced and modern treatment of tuberculosis.

The following questions have been decided upon to be submitted for this discussion:

1. Special hospitals and sanitariums, their construction and operation. 2. What are the most successful methods of treatment? 3. Individualization of certain forms of tuberculosis, its importance and necessity. 4. Is change of climate a necessity for successful treatment? 5. Should the use of anti-toxins in tuberculosis be condemned from a purely scientific point of view?

It is proposed to announce, in the program, the name of one or more experts, who will submit a paper upon each of these questions.

The following committee has been named by the Medico-Legal Society, to act as a committee of arrangements for this congress, with full power, and the profession is desired to co-operate by contributing papers and to taking part in the discussion, and to advise either member of the committee as early as possible.

THOMAS BASSETT KEYES, M. D.,
98 State street, Chicago, Ill.
J. MOUNT BLEYER, M. D.,
460 Madison avenue, N. Y.
CLARK BELL, ESQ.,
39 Broadway, N. Y.

THE SECOND INTERNATIONAL CONGRESS AGAINST THE ABUSE OF TOBACCO is announced to take place in Paris, August 20 to 25, 1900. The fee of membership is 5 francs, which should be sent, together with address, title, etc., to the president, M. E. Decroix, 20 bis, rue Saint-Benoît, Paris. The discussions will be aimed at the thorough consideration of tobacco from the historic, physiologic and chemic, morbific, social and hygienic points of view.

THE LOUISIANA STATE BOARD OF HEALTH has had an interesting episode incident to the arrival of the coffee ship, the *Willowdene*. Notwithstanding newspaper judgment and the interference of the members of the Cotton Exchange, the Board of Health decided that for sanitary reasons there was no cause for prohibiting the admission of the said vessel, after the prescribed regulations of detention and fumigation had been complied with.

THE CHARITY HOSPITAL TRAINING SCHOOL for female nurses graduated eleven pupils on December 14. Miss Nellie Kirby, of Warren, Ala., delivered the salutatory and Miss May Reid, of New Orleans, the valedictory. Reports were read by the chairman of the faculty, Dr. Bloom, and the directress of the school, Sister Agnes. Hon. E. H. Farrar delivered the address of the occasion, which was presided over by Dr. E. S. Lewis, the vice-president of the hospital board.

THE NEW ORLEANS TRAINING SCHOOL FOR NURSES, the poineer training school of New Orleans, has adopted an outdoor uniform, such as is used in some of the Northern institutions. The street dress consists of a pretty and appropriate costume of modest gray, a long circular cloak enveloping the figure and a quaint, widowy bonnet with soft veil of the same shade as the cloak completing the uniform. Upon the square collar of the cloak on the left-hand side is embroidered a crescent, the badge of the institution. This innovation possesses the practical value of being readily donned, while it offers a deserved protection to nurses compelled to be abroad at night.

AN ITALIAN HOSPITAL has been projected for New Orleans in a recent vote for incorporation of the Italian Hospital Association of New Orleans, sprung into existence from the membership of the several Italian societies in this city.

THE EYE, EAR, NOSE AND THROAT HOSPITAL of New Orleans needs aid. No institution in the city fulfils the same complete charity that is daily rendered at this institution. It not only has stimulated the salvation of the organs of the senses of the poor, but it has yearly added to the value of scientific work on the diseases treated. The whole State has profited by its ten years' existence, and it ought to be work of medical men and laymen to see to it that the aid should come quickly and bountifully.

PERSONALS: Among the number of distinguished members present at the recent meeting of the Southern Surgical and Gynecological Association, the JOURNAL noted the following: Dr. A. M. Cartledge, Lewis S. McMurtry, J. M. Mathews, Henry Koehler and H. H. Grant, of Louisville; Geo. Ben Johnston, Christopher Tompkins, H. M. Taylor and Lewis C. Bosher, of Richmond; Joseph Taber Johnson and J. W. Bovée, of Washington; Wm. W. Potter, Buffalo; Geo. H. Simmons, of Chicago; W. P. Nicolson, F. W. McRae and J. G. Earnest, of Atlanta; Geo. S. Brown, W. E. B. Davis and J. D. S. Davis, of Birmingham; Wm. B. Rogers and T. J. Crofford, of Memphis; Manning Simons, of Charleston; I. L. Watkins, of Montgomery; S. C. Milliken, of Dallas; Geo. H. Noble, of Savannah; W. A. Quinn, of Henderson, Ky.; Geo. A. Baxter, of Chattanooga; W. G. Haggard, of Nashville; R. B. Granger, New York, and I. N. Love, St. Louis.

The local members taking part in the proceedings and social functions of the meeting were the following: Drs. E. S. Lewis, F. W. Parham, R. Matas, E. Souchon, W. E. Parker, J. D. Bloom, E. D. Fenner, S. M. Fortier, H. B. Gessner, H. S. Lewis, H. S. Cocram, C. J. Miller.

DR. S. M. FORTIER has been appointed attending physician to the Louisiana Retreat for the Insane, vice Dr. E. T. Shepard, deceased. This appointment follows as a natural consequence, as Dr. Fortier has for a number of years served as assistant. The institution is to be congratulated upon its selection.

DR. JOSEPH MULLEN, of Houston, Tex., has recently returned from the Ninth International Congress of Ophthalmology at Utrecht and an extended visit to European clinics.

MARRIED.—Among the recent benedicts of the medical profession the JOURNAL notes the names of Drs. E. A. Robin, John J. Archinard and John F. Oechsner, of New Orleans, and Dr. E. C. Parker, of Shelby, Ala.

OBITUARY.—Dr. Jules A. Mathieu, one of the oldest homeopathic doctors in New Orleans, died December 7, 1899, at the age of seventy-five. He had been failing in health since last May, but continued to practice up to a few days before his death, which was due to general debility. Dr. Mathieu was born in Bayonne, France, almost seventy-five years ago, and has practiced in New Orleans over half a century.

THE MEMPHIS MEDICAL SOCIETY have elected the following officers for 1900: President, Dr. E. C. Ellett; Vice President, Dr. E. A. Neely; Secretary and Treasurer, Dr. Edwin Williams; Reporter, Dr. R. B. McKinney.

THE ORLEANS PARISH MEDICAL SOCIETY, on December 9, elected the following officers for 1900: President, Dr. T. S. Dabney; 1st Vice President, Dr. M. J. Magruder; 2d Vice President, Dr. E. J. Graner; 3d Vice President, Dr. H. B. Gessner; Recording Secretary, Dr. E. H. Walet; Treasurer, Dr. M. Maguire; Librarian and Corresponding Secretary, Dr. S. P. Deloup.

In accordance with the recent act of incorporation, Drs. E. D. Martin, John Callan and Isadore Dyer were elected as the three members to serve, with the officers, as a Board of Directors.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The Modern Treatment of Wounds. By JOHN E. SUMMERS, JR., M. D. Medical Publishing Company, Omaha, 1899.

In this little work the author treats the subject in a most thorough and interesting manner, beginning very properly with bacteria and their effect on wounds. The subject of asepsis is then dealt with, care of the hands, preparation of dressings, sterilizing of instruments, and the modes of procedure in case of operation. Every variety of wound is dealt with, simple and complicated. The author has undoubtedly had a large experience, and brings to his aid some mechanical devices which, though not new and not all original, are well worth knowing, and not only make the work more valuable but will prove of great assistance to those who have not enjoyed so vast an experience. It is just such a treatise as this we need to emphasize the importance of the care and treatment of the conditions we are so prone to look upon as minor surgery and too simple to require much time or attention. The book is valuable, and the author is especially to be commended for the very complete manner in which the subject is treated.

MARTIN.

The Medical News Visiting List, 1900. Lea Brothers & Co., Philadelphia and New York, 1899.

The usual satisfactory combination of a visiting list with valuable references and memoranda, ranging from signs of dentition to ligation of arteries. It is on good paper and of handsome get up. This list can be "put on the list."

A Treatise on Surgery by American Authors. Edited by ROSWELL PARK, A. M., M. D. Condensed Edition. Lea Bros. & Co., Philadelphia and New York, 1899.

Excellent expresses our sentiments in regard to this new book. Although the list of contributors is in itself a guarantee of the work, one is bound to feel impressed with its completeness when glancing through the pages.

The author has done well to condense it into one volume, as in this form it will prove more popular. We know of no similar work presented to the profession to-day that compares with it. It is the book for the busy country practitioner who, acting as surgeon and specialist, needs a ready reference to use in emergencies. Here in a single volume nearly every phase of surgery is touched upon.

The second chapter, the surgical pathology of the blood, though an innovation in surgical text-books, is a most important addition; we know to-day the great value of blood examinations and how often the report of the pathologist will effect the prognosis. The illustrations are very fine, colored plates being used when necessary to better demonstrate the subjects. It is essentially a modern, fully up-to-date edition on surgery, well written, beautifully illustrated and conveniently arranged. It is especially gratifying to see the names of two New Orleans surgeons among the contributors, a pretty, yet most deserved compliment paid them by the author. This condensed edition of Park's surgery we consider the most complete volume yet presented to the profession, and hope it will meet with the recognition it deserves. MARTIN.

Pulmonary Tuberculosis, Its Modern Prophylaxis and the Treatment in Special Institutions at Home. Alvarenga Prize Essay of the College of Physicians of Philadelphia for the year 1898, revised and enlarged. By S. A. KNOPF, M. D. P. Blakiston's Son & Co., Philadelphia, 1899.

We consider ourselves fortunate indeed to have the privilege of reviewing a work of so much merit as that of Dr. Knopf, the subject dealt with being a momentous one, but the masterly mind and intuition of the author has proved equal to the task of setting it forth. Books of this character are not to be read and laid aside, but should be read and re-read and studied. We hope the book will be an incentive to unite the whole genius of the medical profession to work in concert in an endeavor to discover or suggest means to alleviate, cure and prevent this most dreadful malady. Our work should be to the end to prove the truism of the saying of the immortal Pasteur: "It is in the power of man to cause all parasitic diseases to disappear from the world."

After the introductory a short history of tuberculosis is given, along with much interesting data regarding the disease. Statistics showing the mortality rate in the different countries, also of the principal cities of the world are given. A table compiled in 1890 for the different States shows that Utah, Idaho and Wyoming present the lowest mortality for the United States. It is encouraging to notice that the "mortality has already decreased in these latter years in some of the cities of Europe, thanks to the creation of special hospitals and sanatoria for the poorer classes, and also in a few cities in the United States by the inauguration of a rigorous prophylaxis against the spread of tuberculosis. It is worthy of mention that Rogée, of Paris, claims that in his experience "the autopsy revealed 51 per cent. of healed pulmonary tuberculous lesions."

Every physician should become familiar with Chapter XXIII, "The Treatment of Ambulant Tuberculous Patients in Private and Dispensary Practice." We anticipate a wholesome reception for this splendid work by the medical profession. The volume contains numerous descriptions and illustrations of the most important sanatoria in the world. The typographic work is of a high order. STORCK.

The Hygiene of Transmissible Diseases: Their Causation, Modes of Dissemination and Methods of Prevention. By A. C. ABBOTT, M. D., W. B. Saunders, Philadelphia, 1899.

The era is not far off when hygiene will be taught by professors devoted to that one branch of study, and Dr. Abbott has strongly brought out this point in his book. "Hygiene is not so much a study of man as of man's surroundings, with the view of determining in how far these are conducive or detrimental to his well-being." Dr. Abbott says: "In 1856 the mortality from typhoid fever in Munich was 2.91 per 1000 of population. At that time the soil of the city was honeycombed with cesspools, and a large part of the water supply of the city was obtained from wells and pumps sunk in the soil.

Between 1856 and 1887 the condition of the city underwent, at several conspicuous periods, a radical sanitary reform. The cesspools were filled and the introduction of new ones was prohibited. An elaborate system of sewers was introduced, pumps and wells were abandoned, and a pure water supply was brought from a source beyond suspicion of pollution. As a result of all this the mortality from typhoid fever fell, and in 1887 it had reached the very low ratio of 0.1 per 1000 of population, a reduction of about 96.6 per cent. in the deaths of this disease alone."

The subject matter is arranged under five principal sections as follows: 1. Causation of Disease. 2. The Causation, Modes of Dissemination and Prevention of Special Diseases. 3. Prophylaxis in General Against Infectious Diseases. 4. Important Precautions in the Management of Communicable Diseases. 5. Quarantine. Charts and statistics bearing on the different diseases are given. Attention is called to the high death rate of the negro in Southern and Northern cities. Typhoid, malarial and yellow fever receive careful consideration. The work will repay careful perusal, and should find a place in the working library of every physician.

STORCK.

Practical Anatomy, Edited by W. T. ECKLEY, M. D., and CORINNE BUFORD ECKLEY, P. Blakiston's Son & Co., Philadelphia, 1899.

This book of nearly 500 pages was prepared as a dissecting-room guide to Morris' Anatomy. Gross anatomy only is considered, the student being referred to Morris' Anatomy for the description of the individual organ. The method of studying structures in the normal order in which they are exposed in dissection is followed. The introductory chapter contains certain rules, principles and generalizations which we believe will prove useful to the student. The review-quizzes intended to fix salient points seen in dissection are a commendable feature of the book. There are to be found in the volume 347 illustrations, many of them being colored. We think the student of anatomy will derive material assistance from this work in conjunction with one of the larger works. Though especially intended as a working guide to Morris' Anatomy we believe the student will find it useful, whatever may be the larger book he uses.

PARHAM.

Surgical Anatomy, a Treatise on Human Anatomy in its Application to Medicine and Surgery, by JOHN B. DEAVER, M. D., in three volumes, illustrated by about 400 plates mostly drawn for this work from original dissections. Volume 1, Upper Extremity, Back of Neck, Shoulder, Trunk, Cranium, Trunk, Face. P. Blakiston's Son & Co., Philadelphia, 1899.

This great work, the first volume of which now lies before us, is the product of twelve years' hard work of one of the most practical surgeons in America. While the needs of the undergraduate have been fully kept in view it has been the aim of the author to provide a work which would be sufficient for reference for use in actual practice. We believe the book fulfills both requirements. The arrangement is systematic and the discussion of surgical relations thorough. There are admirable books in other languages, such as that of Joessel, of Strasburg, but we believe no work in the English tongue will fill as thoroughly the needs of the practical surgeon as this book of Deaver's. We shall take occasion as the succeeding volumes are reviewed to speak more in detail: for the present we content ourselves with directing attention to the general excellencies of the book, and heartily commending it to our readers.

PARHAM.

The Physicians Visiting List for 1900—P. Blakiston's Son & Co., Philadelphia.

Aside from the convenient arrangement of the daily account sheets this little book contains a useful dose table and other information of constant service to the doctor.

Materia Medica, Therapeutics, Medical Pharmacy, Prescription-Writing, and Medical Latin. A Manual for Students and Practitioners. By WILLIAM SCHLIEF, Ph. G., M. D. Philadelphia, Lea Brothers & Company, 1899.

The influence of the teaching of Dr. H. C. Wood is apparent throughout the book. Dr. Schlief has here presented much desirable information in small compass. The greater portion of the book deals with drugs, medical Latin and prescription-writing receiving but slight attention.

STORCK.

A Text-Book of Physiology. By WINFIELD S. HALL, Ph. D. (Leipsig), M. D. (Leipsig). Lea Bros. & Co., Philadelphia and New York, 1899.

We like the method of attacking the subject which the author follows. Analyzing first the essentials of life, energy and purpose of living of organisms. the author studies physiology as related to other branches of science. Incidentally the evolution of the science of physiology as a science is reviewed. With such a basis, the logical presentation of the subject is made, the material being subjected to a division in accordance with the evolutionary and rational sequence of vital functions as organisms develop into higher planes of life. The abstract subjects find full consideration, therefore, while throughout each function is made complementary.

The practical detail is complete and as a text-book the volume is commendable. DYER.

Progressive Medicine, a Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M. D. Vol. II, 1899. Lea Bros. & Co., Philadelphia and New York, 1899.

This volume contains comprehensive resumes of work done on diseases of the throat, diseases of the skin, diseases of the nervous system and on obstetrics. To the busy medical man this class of publication supplies the review of current medical and surgical literature, and the editor has the collaboration of men qualified to make the best of the material. The work on each divisional subject is systematically arranged, and the latest treatment of the diseases discussed is given in brief. The illustrations, though limited, are excellent. DYER.

Lea's Series of Pocket Text-Books. Physiology, a manual for students and practitioners. By HOWARD D. COLLINS, M. D. and WM. H. ROCKWELL, M.D. Series edited by Bern. B. Gallaudet, M. D.—Illustrated. Lea Bros. & Co., Philadelphia and New York, 1899.

Lea's series of text-books are written largely for the student, but they are arranged in a practical way which will commend them to the practitioner. The present volume is a clear presentation of physiology, with no special theories, but full of demonstrations and excellent diagrammatic illustrations. DYER.

Treatise of Human Physiology, for the Use of Students and Practitioners of Medicine. by HENRY C. CHAPMAN, M. D. Second edition; Lea Bros. & Co., Philadelphia, 1899.

Compared with other text-books on physiology, this work is especially noteworthy because of the careful experimental detail related. No pains have been spared in making the illustrations adequate to the text. This is especially so in the chapters on reproduction and the circulation. The high grade of editing essential to a comprehensive volume on physiology is evident on every page. The book deserves a careful review, which space here forbids. DYER.

A Review of Recent Legal Decisions Affecting Physicians, Dentists and Public Health, etc., by W. A. PURRINGTON, of the New York Bar. E. B. Treat & Co., New York, 1899.

Too much can not be done to educate the medical profession upon medico-legal questions, and this book of cases cited is a valuable contribution to this end. The cases are arranged so as to be both interesting and readily digested. Exhaustive reference cases are given.

DYER.

Blakiston's Quiz-Compends. A Compend of Human Physiology. ALBERT P. BRUBAKER, A. M , M. D. P. Blakiston's Son & Co., Philadelphia, 1899.

This ninth edition of Dr. Brabaker's book has been revised, and the careful preparation of the author is evident. The work is aimed at a certain usefulness for students, and as such it is among the best of its kind. DYER.

Love and Its Affinities, by GEORGE F. BUTLER, M. D. G. P. Engelhard & Co., Chicago, 1899.

Among the mass of medical literature this little work of 184 pages stands out as a refreshing corollary. Handling the delicate phases of lust and love, its subject matter is full of beautiful phrasing and delicious commentary. The author has written a book on a hard subject and has presented his material in a masterful way, appealing to the reader for a broader view of the psychic, physiologic and social sides of the sexual obligations of man and woman. Every doctor should read it for the good in the book, and meantime he can only gain knowledge with the enjoyment of the perusal. DYER.

PUBLICATIONS RECEIVED.

An American Text-Book of Surgery, Edited by William W. Keen, M. D. and J. William White, M. D.—W. B. Saunders, Philadelphia, 1899.

The Medical New Visiting List—1900—Lea Bros. & Co., Philadelphia and New York.—Lea Bros. & Co., 1899.

Love and Its Affinities, by George F. Butler, M. D.—E. P. Engelhard & Co., Chicago, 1899.

Bulletin of the Laboratory of Mount Hope Retreat—1899—John Murphy Company, Baltimore.

Lectures Upon the Principles of Surgery, by Charles B. Nancrede, M. D., with an Appendix by Wm. A. Spitzley, M. D.—W. B. Saunders, Philadelphia, 1899.

A Text-Book of Embryology, by Clement Heisler, M. D.—W. B. Saunders, Philadelphia, 1899.

Essentials of Anatomy, by Charles B. Nancrede, M. D., Sixth Edition.—Thoroughly revised by Fred J. Brockway, M. D.—W. B. Saunders, Philadelphia, 1899.

Essentials of Physical Diagnosis of the Thorax, by Arthur M. Corwin, M. D.—W. B. Saunders, Philadelphia, 1899.

The Surgical Diseases of the Genito-Urinary Tract—Venereal and Sexual Diseases, by G. Frank Lydston, M. D.—The F. A. Davis Company, Philadelphia, New York and Chicago, 1899.

The Physicians' Visiting List for 1900.—P. Blakiston's Son & Co., Philadelphia.

The American Settler's Guide, by Henry N. Copp.—Washington, D. C., 1899.

Transactions of the American Surgical Association, edited by De Forest Willard, M. D.—Wm. J. Dernan, Philadelphia, 1899.

Report on Formaldehyde Disinfection in a Vacuum Chamber, by P. A. Surgeon E. K. Sprague, U. S. M. H. S., Washington, 1899.

The Modern Treatment of Wounds, by John E. Summers, Jr., M. D.—Medical Publishing Company, Omaha, 1899.

The Urine and Clinical Chemistry of the Gastric Contents, The Common Poisons, and Milk, by J. W. Holland, M. D.—P. Blakiston's Son & Co., Philadelphia, 1899.

REPRINTS.

Constipation—Its Treatment by the Mechanical Measures, by H. Illoway, M. D.

Shipment of Merchandise from a Town Infected with Yellow Fever—Train Inspection in Yellow Fever Epidemics, by Surgeon H. R. Carter, M. H. S.

Mortality Statistics in the United States for 1897—Washington.

Carcinoma of the Duodenum—The Diagnostic Value of Abdominal Palpation in Diseases of the Intestines, by Charles D. Aaron, M. D.

Ureteral Anastamosis, by George H. Noble, M. D.

The Diagnosis and Treatment of the More Common Bladder-Affections in Women by Means of Kelly's Method; Differential Diagnosis Between Extra-Uterine Pregnancy and Early Abortion; Report of a Case of Salpingo-Oopherectomy in Acute Puerperal Sepsis, by Hiram N. Vineberg, M. D.

The Tuberculosis Crusade and Its Problems—Traction Plasters for Temporarily Contracting an Affected Lung in Lieu of the Murphy Operation, by Charles Denison, M. D.

The Reconstruction of the Pelvic Structures Incident to Lesions of Perineum—The Technic of the Buried Tendon Suture—The Aseptic Animal Suture, Its Place in Surgery, by Henry O. Marcy, M. D., Boston, Mass.

Some Notes Upon the Tuberculin Test, by Edward O. Otis, M. D.

A Case of Diabetes Mellitus Quickly Following Mumps, by H. F. Harris, M.D.

New Laboratory Apparatus, by W. M. L. Coplin, M. D.

Akromegaly, by William Nicholas Lackey, M. D.

The Propagation of Diseases by Means of Insects, with Special Consideration of the Common Domestic Types, by W. L. Coplin, M. D.

Anent an Urgent Duty of the Profession, by B. Oettinger, M. D.

Five Hundred and Fifty Surgical Operations Without Alcohol, by Charles Gilbert Davis, M. D.

The New Local Anesthetic "Nirvanin," by August Luxenburger, M. D.

Abrupt Onset in Typhoid Fever, by William Pepper, M. D., and Alfred Stengel, M. D.

Proceedings of the Pathological Society of Philadelphia—The Medical Treatment of Movable Kidney, by Alfred Stengel, M. D.

Gastroptosis; Report of a Case in Which a New Operation Was Undertaken and the Patient Greatly Improved, by Alfred Stengel, M. D., and Henry D. Boyna, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

For November, 1899.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	4	9	13
" " Intermittent	1		1
" " Remittent			
" " Congestive	3	1	4
" " Typho	1	5	6
" Yellow	5		5
" Typhoid or Enteric	7	6	13
" Puerperal			
Influenza	1		1
Measles			
Diphtheria	4		4
Whooping Cough			
Apoplexy	12	9	21
Congestion of Brain	4	1	5
Meningitis	6	4	10
Pneumonia	17	10	27
Bronchitis	7	6	13
Cancer	12	2	14
Consumption	41	34	75
Bright's Disease (Nephritis)	20	22	42
Uremia	1		1
Diarrhea (Enteritis)	26	12	38
Gastro-Enteritis	8	2	10
Dysentery	1	1	2
Hepatitis			
Hepatic Cirrhosis	5		5
Peritonitis	3	3	6
Debility, General	1		1
" Senile	14	6	20
" Infantile	4	4	8
Heart, Diseases of	31	21	52
Tetanus, Idiopathic			
" Traumatic		3	3
Trismus Nascentium	10	5	15
Injuries	11	11	22
Suicide	4	2	6
All Other Causes	97	46	143
Total	361	225	586

Still-born Children—White, 27; colored, 25; total, 52.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 20.63; colored, 30.00; total, 23.44.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.05
Mean temperature	63.
Total precipitation	1.70 inches

Prevailing direction of wind, southeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LII. FEBRUARY, 1900. No. 8.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

LITHOLAPAXY.*

BY GEO. S. BROWN, M. D., BIRMINGHAM, ALA.

A very limited experience with the operation of litholapaxy has led me to believe that it is being unwisely, although not altogether unreasonably, neglected. The most important cause for this neglect is, perhaps, that the cutting operations, particularly the suprapubic, are very easy to do, and the results are very satisfactory. This sounds somewhat paradoxic, however, when we recall the statistics. Those for example in Prince A. Morrow's book, which shows an average mortality for the suprapubic of 18.86 per cent. divided as follows:

Children under 14 years, 591 cases, with 74 deaths, 12.52; adults, 14 to 50 years, 100 cases, with 12 deaths, 12; old men, 53 cases, with 17 deaths, 32.07; average, 18.86 per cent.

Undoubtedly this seeming high mortality must be considerably lowered by the facts. First, that these collected statistics are taken from hospital records; that in hospitals where litholapaxy is done at all the suprapubic cases tend to be the selected bad ones. Second, that very many unrecorded cases are done by the occasional operators scattered over the country, whose patients are for the most part children and young adults and whose results must be correspondingly good.

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*Read at the Meeting of the Southern Surgical and Gynecological Society, New Orleans, Dec. 5, 6 7, 1899.

These discrepancies corrected would undoubtedly show the suprapubic operations in a more favorable light than the perineal section. Still the difference between these statistics and those given for litholapaxy is too wide to be thus bridged over. Statistics taken from the same work for the two other methods are as follows:

For perineal lithotomy:

Children under 14 years, 539 cases, 16 deaths, 2.96; adults, 14 to 50 years, 177 cases, 19 deaths, 11.3; old men, 48 cases, 8 deaths, 16.66; average, 10.31 per cent.

Litholapaxy:

Children under 14 years, 241 cases with four deaths, 1.66; adults, 14 to 50 years, 400 cases with 13 deaths, 3.25; old men, 433 cases with 26 deaths, 6; average, 3.64 per cent.

Gross' general table, published in 1882, of 13,570 operations by cutting methods, including all ages and without selection of cases in any way, and by many hundred operators in this country and Europe, shows a mortality of 12 per cent.

Keegan* reports, litholapaxy, 10,073 cases, mortality, 3.96 per cent.; lateral lithotomy, 7201 cases, mortality 11.02 per cent.; suprapubic, 147 cases, mortality 42.17 per cent.

This, as he says, shows that there are many skilled litholapaxists in India and also that there is a strong bias there against the suprapubic method. So that the strong inference is that the suprapubic was resorted to in most of these 147 cases because the stones could not be removed in any other way, that is they were selected bad cases.

Another of the reasons assigned for not using the crushing operation aside from the tempting ease with which the suprapubic is done is that the number of stone cases occurring in the practice of the average surgeon is so limited he does not have opportunity to develop sufficient skill to make it worth his while. This seems to be one place where a limited experience may be worth something, so I shall here give the result of mine, as showing that when the occasional operator who is careful to follow instructions may find it worth his while to crush in such cases as are at least most favorable to the operation.

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* *Lancet*, January 30, 1897.

My first case was briefly as follows:

MR. F. H., age 50. Had been a sufferer since boyhood from cystitis, due to injury. In 1887 he was cut through the perineum for stone by Mastin, of Mobile. In January, 1897, he again had symptoms of stone; he discovered it himself while passing a sound for strictures. In May, 1897, he insisted that I should get a lithotrite and try to crush it, as he did not have the time or patience to spare for being cut again. He was suffering a good deal, and getting up to urinate every half hour at night, which was beginning to tell upon his general health. I met with no difficulty in the operation except that his urethra was the seat of numerous strictures which had first to be cut and dilated. The stone, a soft phosphatic one, weighed about 70 grains. The first night after the operation was the most comfortable he had had for three months, and the next day he was up and about the hospital, the third day he went home, and the fourth day to his office.

His bladder was washed out daily for three weeks, or until the mucus had entirely disappeared. For the first few washings a few fragments of the stone were brought away together with a great deal of muco-pus. It is now two and a half years since the operation, and he has had no return, and the cystitis seems about well.

My second case was an old man of 73. In May, 1897, he bruised his perineum, rupturing the urethra and causing a large abscess, which was opened by some homeopathic surgeons. After the pus was evacuated they put a soft catheter into the bladder through the urethra, reasoning that the fistula could not close if not kept free from urine.

This catheter was left in four weeks before an attempt was made to remove it, the attempt was not successful, and six weeks after the introduction of the catheter, July the 8th, 1897, the patient was brought to me. The catheter was incrusted inside and out with the earthy deposit and was immovably fixed in the urethra. Under ether I passed a No. 8 French sound forcibly through the lumen of the catheter supposing that a stone had formed at the eye. This proved to be correct as I felt the stone break off under a slight pressure.

The incrusted catheter was removed forcibly and the bladder washed out, but the old man's condition was so bad it was thought best to wait until later to crush the stone if there was one there, which was conjectural as a good many fragments came away in the washing and no stone was found after a limited search. The bladder was washed out daily for two weeks when the fistula closed and the urine was clear, and he was discharged. A few weeks later, about October, 1897, he again had irritation and inflammation of the bladder; he again resorted to homeopathic treatment, which he continued until May, 1898, when he came back to me. He had a soft phosphatic stone 1 inch in diameter; this was crushed and washed out in about one hour and a half. He had slight fever for two days but was up on the fourth day. At the end of ten days the muco-pus had all disappeared from the urine and he could retain his urine from four to six hours. It is now a year and a half since the last operation and he has had no further trouble.

My last two operations were on one patient, H. B., age 50, coal miner; had had four suprapublic cystotomies in the previous ten years for recurrent stone. He said he was never free from symptoms of stone for very long after any operation, and after the last one, November, 1898, the period of relief was shorter than usual and he had been passing his urine almost every hour the whole time until he came to me May 27, 1899. The stone as measured by the grasp of the lithotrite was about one inch in diameter and was quite soft, so soft that it clogged the instrument frequently and required over two hours for the operation. He passed his urine only three times the first night, and said next morning that he felt a great deal better than he had felt any morning for six months. He did not see why he could not go home; he went out and did not report until August, three months later, when he came back with another stone about half as big as the first one.

He was instructed at the time of his discharge in May to wash his bladder out daily until all the muco-pus had disappeared. He confessed that he had not done this a single time. This second stone was crushed between eleven and one o'clock. The patient slept until five, and then went home on the train, saying he was going to work the next morning, and he has not since reported, though I have heard through his physician in the last few weeks that he has had no further trouble.

[Note.—On December 9, 1899, I again operated upon this third patient, H. B. (This third crushing operation.) The stone was a soft phosphatic one. The whole operation of washing the bladder, catching and crushing the stone and washing out the debris occupied thirty minutes. It was done, too, without causing a tinge of blood to the water contained in the bladder. The first night he passed his urine twice instead of twelve or fifteen times as he had been doing before. He went out next morning and has been reporting since as an office patient to have his bladder washed out.]

I report these cases more to show that the operation is not as a rule a difficult one for the beginner, than for any special clinic value they possess.

The operation is applicable to all stones of moderate size which are not encysted in a diverticulum of the prostrate or the bladder wall, and which are not too hard or too large to crush. Under these restrictions probably the majority of stones in this country can be managed with the lithotrite. It is true that Brigade Surgeon Lieut.-Col. D. F. Keegan, of the British army in India, in an article in the *Lancet* of January 30, 1897, is not encouraging to the occasional operators, as all surgeons of Europe and America are to be regarded in relation to the stone operation.

He shows that the mortality in his own work and that of his brother experts, Forbes-Keith, Freyer and Baker and others, shows a steady and marvelous fall as they gain in experience, notwithstanding the fact that as they progress in skill they operate on more and more difficult cases. Their mortality has averaged from about 14 per cent. in the beginning down to 1 and 2 per cent. in their later work.

Richard Baker, indeed, for two years had had up to September, 1897, 404 operations with only two deaths, less than half of 1 per cent. Keegan also warns the beginner not to be over-confident because his first few cases have been successful; that the trouble will come sooner or later to the inexperienced. My cases have all been soft phosphatic stones, which, though less difficult to crush, are more difficult to catch on account of their lightness, and require a longer time to crush and wash on account of the clogging of the blades and the tenacity with which the mucus-covered walls of the bladder hold these lighter particles. Baker gives the average time of 204 operations as twelve minutes and nineteen seconds. We can believe this only on the assumption that the greater number of the stones were small, heavy, primary, acid stones, but which were not too hard to be easily crushed.

I shall not weary you with a review of the history, cause of, and distribution of stone, nor of the history of the various operations for its relief.

I shall only say a word about the accepted theory of formation of the stones as being important in indicating the after treatment quoted briefly from the article by E. L. Keyes in Ashhurst's Encyclopedia, which is the most complete essay on the subject of stone I have been able to consult.

George Rainey first showed at St. Thomas' Hospital, in London, that certain crystalline materials assumed globular forms when precipitated in gummy solutions and he announced his mature doctrine of "molecular coalescence and molecular disintegration" in an article in 1858 on the mode of formation of shells in animals. His researches led him to conclude that a law existed by which organized bodies assumed a rounded form on account of physical and not on account of vital agencies.

The following was Mr. Rainey's process: a solution of gum arabic saturated with a solution of carbonate of potassium of sp. gr. of 1.4 and two slips of glass which were introduced into the liquid and the whole set aside for a month.

In this way he succeeded in forming perfect spheres of carbonate of lime having all the hardness of pearls, and he demonstrated that they were built up by slow coalescence of minute molecules. Mr. Rainey concluded that the viscosity of the gum destroyed the polarity of the crystals, which would otherwise form, and the molecules simply obeyed the law of mutual attraction and built themselves by fine concentric layers into spheres with which the gum was intermixed.

When these spheres are placed in a new solution of gum of different sp. gr. they lose their laminated arrangement, split radially and return to their molecular condition, a process termed by Mr. Rainey "molecular disintegration."

This splitting of a concretion in a fluid of a different sp. gr. from that in which it was formed, is beautifully illustrative of what sometimes take place in the human bladder in the spontaneous fracture of a stone.

Wm. M. Ord followed up Rainey's investigation with some excellent independent researches directed mainly toward investigating the formation of urinary and other calculi, publishing the final result of his labors in 1879 in a paper entitled "The Influence of Colloids upon Crystalline Form and Cohesion."

Dr. Ord's second proposition is the following:

"A crystalloid is deposited from the solution in the presence of a colloid. This occurs in uric acid and urates mixed with albumin and mucus, in nitrate of urea crystallized from albuminous urine. His third proposition in part is that uric acid exists in three forms.

1st—Rectangular oblong colorless plates, pure uric acid.

2nd—Rhombohedra and their modifications, urinary uric acid.

3rd—Spherical forms, calculous uric acid.

Ord states that number one is the proper crystalline form of uric acid, and that the changes in the form which the urinary crystals present are assumed in obedience to Rainey's law of molecular coalesence and vary with the quality and quantity of colloid substances which the urine contains.

Four substances in normal urine influence the forms of crystals; mucus, urea, extractive coloring matter, and salts; to these must be added the ingredients of pathologic urine, capable of modifying crystalline form: Albumin, sugar, blood and pus. Heat intensifies the action of a colloid, and a colloid in partial degeneration seems to be particularly active. Such a colloid is purulent mucus."

I have quoted this passage almost entire to show that we have the soundest scientific reason as well as our clinic experience urging the importance of getting rid of the muco-pus, that is, for treating the vesical catarrh after operations for stone in order to prevent recurrence of the stone. Indeed those who have had most experience say that with proper after-treatment there are hardly any recurrences at all following litholapaxy. While we know that after the cutting operations, for secondary stones at least, recurrence may be said to be the rule. The reason for this

I think is plain. In the first place, the idea of some that the fragments left after the litholapaxy ought of necessity and do cause recurrence oftener than occur after the cutting operations is fallacious, because they probably just as often follow litholapaxy, with this further fact against the former, that the cut bladder is flaccid and paralyzed and has no power of cleansing itself, while the bladder after litholapaxy has more activity than normal and will usually cleanse itself of all debris in a few days without artificial aid.

It is probable that in some cases the new stone begins to form after a cutting operation before the wound has closed, because of the vesical catarrh and the consequent muco-pus which clings to the walls of the bladder. It may form, too, upon the ragged edge of the wound or upon a stitch or a catheter left in the bladder; such rapid recurrences of course are confined to the secondary phosphatic stones due to vesical catarrh.

I have purposely confined this paper to the treatment of stone by litholapaxy, or rather to a plea for such treatment. I have said nothing of the history of the operation (which is the history of the evolution of the lithotrite), nor of the technic of the operation, both of which are very fully written of in all of the text-books. I only urge that the majority of stones met with in practice in this country can be removed with the lithotrite in the hands of ordinarily careful surgeons, and, while it is not an operation to be undertaken by the general practitioner, that no operating room should be without one; that the suffering and time spent in bed are almost entirely eliminated and that the mortality is very much lower than that for either of the cutting operations. Keegan says that, in India, crushing through a perineal incision will gradually take the place of suprapubic lithotomy in the larger number of those cases where the stone is encysted, or for other reasons can not be crushed through the urethra; a small percentage will still be left, however, that are too hard to be crushed even then, and the suprapubic will be resorted to as a last choice. My time is too short and my experience has been too limited for me to say anything new on the details and technic of the operation, so I shall only refer you to the articles by E. L. Keyes, in Ashhurst's Encyclopedia, and by A. T. Cabot, in Morrow's System.

Both are very full and satisfactory. I have one important exception to make to this, however, and that is the advice given in Cabot's article to tie a catheter in the bladder in cases with enlarged prostate where the bladder is not able to empty itself. It is just in these cases where a catheter will often act as a foreign body and cause a rapid deposit of lime salts. It would probably be much better to pass a catheter and wash the bladder out every hour than to leave one there for any length of time. It is unnecessary also for me to say much about the lithotrite, although a history of its evolution from the crude beginning of Civiale to the present day perfection is very interesting reading.

The present day instrument is really the invention of Horteloup, improved in a few minor ways by Bigelow, Thompson and others.

Bigelow's epoch-making discovery was, of course, the idea of crushing the stone and washing it out at one sitting.

Dr. W. S. Forbes, of Philadelphia, has made some systematic tests as to the amount of force necessary in crushing the different forms and sizes of stones. He found that of 300 stones a very small number required a crushing force of 200 pounds, only one went above 300, while a good adult sized lithotrite is capable of exerting a pressure of 600 pounds.

Professor Forbes also has improved the lithotrite. His is perhaps the strongest that has yet been made, each instrument is tested and the test number of pounds marked on the handle. It also by improvement in the fenestrum reduces to a minimum the clogging of the jaws when a soft stone is crushed. This clogging I found very annoying in my cases, because the instrument I have is not properly fenestrated. The authorities say that about five-sixths of all cases are hard primary acid stones. But in this country primary stone is rare, while secondary soft phosphatic stones, being due to vesical catarrh and foreign bodies, must constitute a large portion of the cases, because these causes are equally operative everywhere. This is a final point in favor of litholapaxy in this country, viz.: that these soft secondary phosphatic stones occur most often in old men, and it is in old men that the mortality of the suprapubic operation is particularly high.

A TYPE OF ENTERIC FEVER—NOT TYPHOID.

By OTTO LERCH, A. M., M. D., Ph. D., Chief of Clinic to the Chair of Materia Medica, Therapeutics and Clinical Medicine, Medical Department, Tulane University, etc., New Orleans.

Under the term typhoid fever, a large number of varieties of this febrile disease have been described, some of which derive their name simply from a complication or a prominent symptom occurring during the course of the disease. They present otherwise no essential variation of the type. J. W. Brannan describes five varieties, each of which differs essentially from the other and gives a clinical picture by which it may be recognized: The mild form, the abortive form, the afebrile form, the ambulatory form and the acute or grave form. The mild form has the enlarged spleen, and the rose-colored spots, usually, and the enteric lesions in common with all other forms and differs essentially by its mild course only. The abortive form begins with severe symptoms, a sudden onset with a rapid rise of temperature; enlargement of the spleen and appearance of rose-colored spots as early as the second or third day; frequent constipation, far more so than diarrhea, and early establishment of convalescence. According to Griesinger, defervescence occurs in some cases as early as the fifth day. The afebrile form differs from the other forms of the disease by the absence of an elevation of temperature, great prostration, and great mortality.

The ambulatory form is especially marked by its slow and mild character, always during the first part of the disease and frequently throughout its entire course; the acute form begins with very severe symptoms and usually tends towards a rapidly fatal finale. It is now universally agreed that the cause of this number of various and distinct varieties is due solely to the bacillus typhosus, and that there is no such disease as typhoid fever without this pathogenic bacillus. This opinion is based upon the labors of Von Recklingshausen, who published in 1871; of Eberth, 1880; Koch, Gaffky and many other observers since then. The bacillus has never been found in a healthy subject. From a typhoid patient cultures may be readily obtained from the spleen and lymph nodes of the mesentery; they are found in the liver and kidneys, sometimes in the blood, the urine and feces. A negative result, however, of an examination could not be considered a positive proof of their absence in the organism. Cabot, for instance, has this to say of the examination of the blood, "Although the bacilli of Eberth are occasionally to be found in the blood by culture, it is only in the most marked cases that they occur."

The identification of this bacillus is exceedingly difficult, and it has been occasionally confounded with the bacterium coli communis discovered by Escherich in 1887. This is not all. Thatcher, after a study of the literature, thinks that the term colon bacillus applies to a species which comprises many varieties of similar bacilli, but which are distinguished from each other by slight biologic and micro-chemic differences. The colon bacilli in general closely resemble the typhoid bacilli in form, size, staining properties, biologic characteristics and pathogenic effects upon certain of the lower animals. The distribution and arrangement of these bacilli in the tissues are practically the same as in the typhoid bacillus. They are found constantly in the intestinal canal and feces of human beings, and in those of many, it not all, of the lower animals. Yet there are distinguishing features that allow us to differentiate the one from the other. As mentioned, however, it is a task involving great difficulty and requiring skill and care. Abbott says that on account of the morphology and cultural peculiarities of this organism, and because of the difficulty experienced in efforts to reproduce in lower animals the conditions found in the human subject, typhoid fever is bacteriologically one of the most unsatisfactory of the infectious diseases. The variability constantly seen in pure cultures of the typhoid bacillus itself in no way renders the task more simple.

Experiments on animals show that the typhoid bacilli proliferate in the bodies of animals, though in a limited degree only; that the animals are killed by a toxin produced by the bacilli, and the enteric lesions produced in man *may be also produced by the bacterium coli in lower animals.*

Considering the many varieties typhoid fever presents, of which only the most marked have been mentioned, and the large numbers of doubtful cases every practitioner has met with, it does not seem strange to ask the question whether all really are due to the same pathogenic agent; that is, to the bacillus of typhoid. On the contrary, it seems probable enough that different bacilli of a certain relationship cause similar symptoms. Such a bacillus, always with us, is the colon bacillus, and while not generally considered pathogenic, there is, nevertheless, sufficient evidence to warrant the statement that, under favorable conditions with which we are not entirely familiar, this organism may assume pathogenic properties, and that its presence in diseased conditions is not always to be considered as accidental, though this is frequently the case (Abbott). The following case tends to prove, I believe, that we have a type of enteric fever, not typhoid, and which is probably caused by one of the varieties of the bacterium coli communis.

I regret that this report, owing to various circumstances, is incomplete, and especially that the case has not been studied bacteriologically. I think, however, it will be found of sufficient interest to call the attention of other observers to this, which I take to be a new disease and for which I would suggest retaining the name enteric fever in contradistinction to typhoid fever:

MICHEL SMITH, forty-three years of age, born in New Orleans, where he has spent most of his life, laborer by occupation, recently engaged in work on the river levees. Patient was admitted December 1, in ward 24 of the New Orleans Charity Hospital, in the service of Professor Reynaud. Hereditary history was unsatisfactory; of the diseases of childhood, the patient claims to have had whooping cough only; contracted yellow fever in 1860; gonorrhea when "young;" chills and fever (malaria) in 1875. He denies having had syphilis and does not give a previous history of typhoid fever, continued fever, or slow fever.

Twelve days before his admittance, he commenced to feel bad but continued work and claims to have had no fever till the day before his admission, when he was attacked with high fever, no chill. Next day, that is on the first of December, he was admitted.

Has no complaints to make and does not feel any pain; states that he has no appetite; that his bowels are regular, rather loose and that he sleeps well.

Present state: A man 5 feet 6 inches; weighing about 130 pounds, muscles well preserved, fat somewhat wasted. Lies on his back with an apathic expression; face of dusky color; skin dry and hot; no edema; no exanthem; abdomen and back carefully searched for rose-colored spots, and morning temperature 102 deg.; pulse 28 to the quarter, regular and fair; radial arteries soft, straight and easily compressible.

Respiration, nothing abnormal. Nervous system, sensorium clouded.

His answers are slow, as if he had to collect his thoughts, but they are intelligent and to the point. No tremor—reflexes present. No headache, lips pale, tongue dry and red, steady, white coating in centre.

Abdomen normal in appearance, tenderness on pressure, and he flinches. Spleen smooth, sharp and hard border, readily palpated; the same impression is conveyed on palpating the liver just protruding in mammary line below border of ribs. Lungs normal. Heart dullness normal and sounds pure. Urine: Sp. gravity, 1020; reaction, acid; no albumin; no casts; no sugar; no bile; color dark, that of a concentrated fever urine.

Blood: plasmodium malariae not found; Widal's reaction positive. December 7, urine free of albumin and casts, and free of sugar and bile. Diazo-reaction negative; blood, free from plasmodium malariae; red cells 4,960,000, white corpuscles, 30,000. On the morning of the 4th, I noticed an eruption which had suddenly appeared during the previous night, and was covering the trunk and partially the extremities.

Dr. Dyer, who kindly saw the case with me, suggested the following description: Location somewhat irregular, distributed especially over the chest, abdomen and back, while the extensor and flexor surfaces of the arms and forearms are involved. The arrangement is unusual for any of the accepted types of erythema which I have seen or about which I know. This consists in festoons arranged in gyrate and scalloped patches, with here and there rosettes of macules of a violaceous red. Some of these are garlands of three or four inches in length, made up of circles gradually fading from the periphery to the center, but everywhere a shade of lavender and red. The color is much more deep on the trunk than on the extremities and every patch fades on pressure.

Dr. Dyer stated that the erythema was entirely different from anything described in connection with typhoid fever, and it was certainly different from anything the writer has seen with this disease. The doctor agreed with our diagnosis, "a severe infection due to a source in the intestines," and thought that "the eruption resembled one due to some intoxication, either with a drug or an intestinal poison; though these usually differ from the one under consideration in the degree of intensity."

The erythema commenced to fade the second day after its appearance and had disappeared entirely in four days. No new eruption occurred at any time thereafter. No rose-colored spots.

Under an appropriate treatment the patient gradually improved, the dusky color of his face cleared and gave place to a perfectly natural one. His intellect became brighter every day; his appetite improved, and the tongue became moist, though on the 11th its white coating, which never had disappeared entirely, turned bluish-black. (I have noticed this coating of the tongue in other severe febrile diseases in my hospital ward on previous occasions. Circumstances have prevented me so far from studying it bacteriologically.) The pulse remained fair at the average of 100 per minute; heart dullness never increased and at no time was there any pain over the precordial region; apex beat always weak. The general feeling improved up to the day of his sudden death, due to heart failure.

The treatment was directed at the general condition of the patient and the seat of the trouble—the intestines.

Absolute rest in bed from his admission in the ward to his sudden exit was strictly enforced, and a liquid diet, consisting chiefly of milk, ordered at stated intervals. In order to combat the toxemia, he was encouraged to drink cool water freely and a liberal sponging with lukewarm water was occasionally resorted to. The bowels were kept open with full water enemas administered in the morning.

To strengthen the heart muscle, threatened by the severe intoxication, strychnia, in the form of the tincture of nux vomica, and alcohol, in the form of milk punch, were given. To this medical treatment were added small doses of Fowler's solution and the elixir of bitter iron. Hot fomentations, later Preisnitz bandages were applied around the abdomen to relieve intestinal inflammation. The patient died suddenly, without warning, on December 18.

Autopsy held by Dr. Pothier, pathologist to the Charity Hospital, by whom also the blood count and the examinations of the urine were made. Lungs, right, 21 oz.; left, 19 oz.; heart, 10 oz.; spleen, 16 oz.; liver, 4 lbs.; pancreas, 3 oz.; kidneys, right, 9½ oz., left, 8 oz. Body emaciated; conjunctiva normal; pupils dilated. Post-mortem rigidity marked, and post-mortem hypostasis slight.

Heart of a dead lead color, fatty, edges of mitral valves ragged.

Lungs normal, post-mortem hypostasis marked.

Spleen enlarged, congested, capsule thickened, of a dark red color.

Liver of a brownish-red color, slightly congested; gall bladder nearly empty.

Pancreas normal.

Small Intestines. Ulceration of Peyer's patches; patches are healing. Some patches entirely healed. No perforation.

Kidneys. Large, of a pale red color, organ hard, fibrous, some fatty degeneration, diffuse nephritis.

Brain. Thickening of pia mater, which is milky, and excess of fluid in all ventricles.

This case presents the post-mortem lesions of typhoid fever.

We find the degeneration of the heartmuscle, but not the more common albuminous and granular, but the fatty degeneration of more rare occurrence.

Spleen. The enlargement of this organ so prominent in typhoid fever is present, the dark red, tense and smooth spleen corresponds to that seen in typhoid fever.

The liver is congested, but the gall bladder, the favored seat of the typhoid bacilli, is intact and an enlargement of the mesenteric lymph nodes is not mentioned.

The kidneys are enlarged, cortex thickened and the color is of a pale red. A characteristic kidney of typhoid fever and so are the lesions of the intestines, the ulceration of Peyer's patches.

From this autopsy nothing but a case of typhoid fever with almost characteristic lesions could be diagnosed.

If we consider, however, the record with the clinical symptoms, the fatty degeneration of the heart of rarer occurrence in typhoid, the intact gall bladder and the not enlarged mesenteric nodes become of significance.

The peculiar range of temperature, the characteristic eruption and the enlargement of the spleen are considered the most important symptoms from which to make the diagnosis of typhoid fever. Tenderness over the abdomen. Meteorism.

The prostration and typical facies frequently present, and the tremor, especially of the tongue, never absent in a case of typhoid, aid to make the diagnosis certain. Recently the Widal test has been added to assist to make a correct diagnosis. In considering this test we find, however, that the substance present in the blood of typhoid patients, causing the agglutination and the arrest of motion of the bacilli, is sometimes present in other diseases and even in health, and if on making such a test we find that the bacilli rapidly clump and become motionless, we may conclude only that the patient has *probable* typhoid fever. To observe a pseudo-reaction is at least not exceedingly rare, and even if all precautions have been observed and a dilution of 1 to 50 used, yet in 1 or 2 per cent. of other diseases a positive reaction has been seen. S. H. Von Ruck, in a paper entitled "The Widal Reaction in Tuberculosis," observes that a true Widal reaction is not to be obtained with the blood of tubercular patients; but what may be termed a modified reaction does occur *quite uniformly*, the difference being one of time and degree only. Another important factor in diagnosis of typhoid fever is the examination of the urine, and it is the diazo-reaction that gives results almost equal to the Widal test.

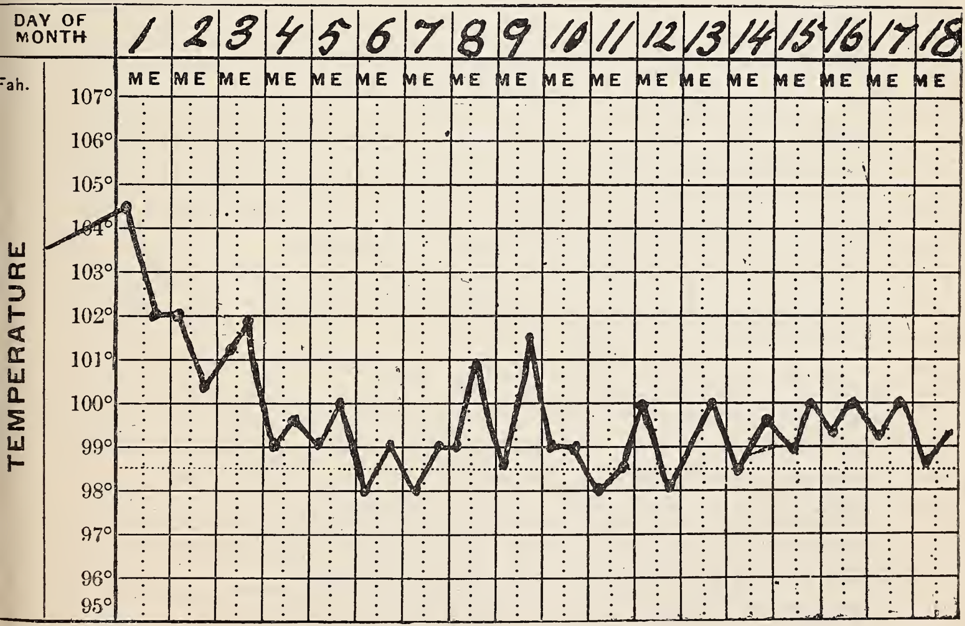
The reaction was described by Ehrlich in 1882; Edwards reported 130 cases, and found it absent only in two cases; Hewetson found it present in 136 out of 196 cases; Brannan, concluding from his own observations, believes it present in 95 per cent. of all cases of typhoid fever, provided they are seen in the first or second week of the disease.

Krokiewitz, who has studied this subject in 1105 cases of typhoid fever and has applied 16,167 separate tests, concludes that the reaction even in mild and abortive forms of this disease is always present in the first or second week. Later it may be less marked or absent. He looks upon it as a symptom of the disease, and so long as it is present the morbid process is not complete. The blood examination is of most valuable diagnostic importance, and the absence of an increase of white blood corpuscles is striking.

Cabot thinks that in all cases in which a leucocytosis constantly exists a complication is present. All observers agree that exceptions are extremely rare; but of 494 cases examined by Thayer he found the *averages:* First week, 21 counts, 6984; second week, 50 counts, 6468; third week, 40 counts, 6260; fourth week, 28 counts, 5877; fifth week, 16 counts, 6621; sixth week, 5 counts, 7000.

These observations were confirmed in four hundred and ninety-one cases at the Massachusetts hospital. Serious complications raise the number of white cells and Cabot quotes cases of perforation, phlebitis and otitis media, in which he observed a leucocytosis of the cases of perforation, two showed the largest number, 18,500 and 24,000, the others ranging between 12,000 and 16,000 white blood corpuscles.

He concludes by saying that in few diseases the blood count is so often of value in diagnosis as in typhoid fever.



Thayer thinks, after his exhaustive researches, that in no case of suspected typhoid should a blood count be neglected and the proportion between the various varieties of white cells should be determined.

If, after this short review of the diagnosis of typhoid and the value placed upon the various means by clinical observers, we consider the symptoms of the case reported we find that it resembles an atypical case of typhoid. On the other hand, however, we see important symptoms missing and others present, not observed in this disease.

The fever chart does not resemble one of typhoid, not even one of an atypical case. The onset, according to the history, is sudden, though prodromes seem to have preceded it. The eruption is peculiar and entirely different from any described in this disease, and does not resemble the erythema or scarlet rash sometimes preceding the appearance of the characteristic rose-colored spots. Tremor is not present, especially not of the tongue, a sympton constantly met with in a case of typhoid.

The examination of the urine shows the diazo-reaction absent, according to Krokiewitz one of the most important symptoms of the disease, and the blood count shows an enormous increase of white blood corpuscles, never met with in an uncomplicated case of typhoid fever. On the other hand, we have the symptoms of an infection: clouded sensorium, the almost typical facies, the dry and pointed tongue, the tenderness on pressure over the abdomen, the enlarged spleen, the congested liver and the positive result of Widal's reaction, and most of all, the autopsy revealed the typical lesions of typhoid.

However, the gall bladder was found intact, and the mesenteric lymph nodes were not perceptibly enlarged. The degeneration of the heart was fatty.

The foregoing summary, I think, justifies the conclusion that this case represents a type of enteric fever, not caused by the bacillus typhosus, and that this disease is due to a specific cause, probably a species of the bacterium coli communis. The close resemblance of this bacillus to that of typhoid spoken of before, practically the same distributions of both bacilli in the body, both causing the same lesions in lower animals, permit such a belief, although unfortunately bacteriologic studies have not settled this question in this case. If further investigations should confirm the existence of such a disease, I think that the case under consideration will merely represent a type of many varieties similiar to those of typhoid, and may serve to explain many doubtful and sporadic cases. It is hardly necessary to point to the importance of the differentiation of an epidemic disease originating outside the body and one that can not be communicated, the cause of which is constantly with us. Besides it would relieve our typhoid statistics, for which so much has been done by a more thorough knowledge of the diagnosis of malaria.

Recognizing this, to call the attention of others to this subject, I publish the foregoing case; being, I repeat, well aware of its incomplete record and study.*

Thanks are due to Mr. R. C. Kemp, resident student, for kind assistance.

Clinical Lectures.

[Specially reported for the JOURNAL from the Philadelphia Clinics.]

CASE OF MULTIPLE NEURITIS.

BY DR. C. K. MILLS.

The patient's statement is that she is thirty-six years old, married, has been well until last August when she had some sort of pain with a constriction across the chest under the clavicle. It passed away as simply a nervous condition; then in October she had a miscarriage with considerable hemorrhage. Since then she has had her sickness rather regularly, but it has been scanty. About fourteen days ago she noticed a stiffness and numbness in both legs and in hands; she could hardly walk. She also had what she describes as a loss of sight, something like a lot of smoke appearing before her eyes. She could not see and was dizzy.

It is a rather obscure history, but in the practice of medicine unfortunately, or fortunately, we do not always have things cut to order. Typical and definite cases are easy enough. Let us see. Now look at those feet. I have told you before you should look as much as you listen. Old Dr. Chas. D. Meigs used to say that a physician who could not tell something about a patient, if there were something the matter with him, by his appearance when he came into the room, had mistaken his vocation. One foot tends to the varus position; the other also slightly. It may be nothing, on the other hand it may be the key to the case. She has a want of power over her limbs, strange to say there seems to be more power in the left foot than in the right. She has no knee jerk. Remember there is another jerk which should be examined, the tendo Achillis jerk. It is often neglected. It is best to examine it on the knees. The tendo-Achillis jerk is simply the jerk you will find if you get on your knees and strike the tendo Achillis, a normal jerk. It is not present in this case; there is a jar that is not the jerk at all. The gastrocnemius jerk is diminished. The left hand shows a partial wrist drop. She says she does not use alcohol of any sort. She has had three miscarriages.

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*Since the foregoing article has gone to press Dr. Thayer calls my attention to Gwyn's case quoted by him in "Progressive Medicine," a case showing the clinical symptoms of typhoid fever with Widal's reaction negative, no autopsy, the disease being produced by the paracolon bacillus. This, I think, is a case somewhat in point.—LERCH.

Let us sum up the case: She has some blunting of sensation and some hyperesthesia. The history is pretty good, yet it would mislead you without any examination. She began to lose power two or three weeks ago, and this is the real beginning of the present condition. There was pain in the limbs, paresthesia, numbness and deadness. On making examination we find that she has lost power distinctly, and probably all these symptoms have been somewhat augmented in these two weeks. She has now loss of power, partial motor paralysis in both legs and in both arms, but more in the left arm. She is diplegic; all four extremities are affected with motor loss. There is partial foot drop and partial wrist drop. When I examined that woman, though I had no intention of hurting her, she had very distinct pain on pressure and on handling, anywhere along the course of certain nerves. If I take the foot and press laterally, there is pain, more in the upper arm when I press along the median nerve. There is loss of knee-jerk, of the tendo Achillis jerk; the gastrocnemius jerk is better on one side than on the other. There is some objective loss of sensation, some anesthesia dolorosa. Certainly one thing is present, and that is multiple neuritis, if symptoms count for anything. It is almost a typical case of the moderate form of the disease. It is multiple neuritis, whatever else it is, and a beautiful clinic lesion. The symptoms are pain on pressure over nerve trunks and regions where nerve terminals are distributed. The lost knee-jerk evidences that the nerves supplying the patellar ligament and the nerves going to the quadriceps are involved. She has the irregular diffused paresthesia and anesthesia. Multiple neuritis when I began to study was an almost unrecognized disease, and this case would have been set down as myelitis, or, perhaps, hysteria, fifteen or twenty years ago.

The causes are various; alcohol is one of the most common of them. It is a curious fact that this occurs among women not infrequently, among beer-drinking women. In three months I saw three or four of these cases in private practice. Of course, to develop this they need to take a good deal of alcohol usually. But alcohol is not the only cause; there are twenty causes given in medical literature, diabetes is one. Any infectious or toxic agent can produce multiple neuritis; rheumatic poison may, and I have seen an extraordinary case from arsenic poisoning. Tuberculosis and syphilis sometimes may be responsible. Syphilis has an elective tendency towards parts of the nervous system, but it does not often attack the spinal peripheral nerves. I have seen a most exquisite case—exquisite in the suffering it produced—in a physician, from tuberculosis. It was almost impossible for him to be kept in any position except under the influence of morphia.

Multiple neuritis, under favorable circumstances, tends to get well, when compared with other nervous affections. There may be recovery even when there has been entire paralysis in some of the extremities. Or the patient may get up half paralyzed after the sub-acute inflammation. In a small percentage of cases the disease spreads, and the patient succumbs to what looks like Landré's paralysis.

In treating this woman we should proceed steadily and carefully. First, she should be put in a room in the hospital, and not allowed to move hand or foot. She should have absolute rest until her condition is relieved. All this half-rest and quarter-rest and partial rest don't do any good in these cases. The first essential, then, is rest, absolute rest. I would take small narrow sand bags, and put them between the legs, and one at each side, then one could be put at the feet, and splint them there. Splint the arms or confine them. Two times a day use hot water applications. Sponge her from the waist down with water at a temperature about 110 degrees, moving her as little as possible. Dry off gently. Wrap up the legs between times with rubber dam.

Internally I would put her on a partly specific treatment, which would be beneficial, at any rate. We will give her a combination of the sodium salts.

Salicylate of sodium	gr. x.
Bromide of sodium	gr. x.
Iodide of sodium	gr. xv.

We will give this largely diluted.

She has complained of a good deal of pain, and it is a question how much we should do to relieve it. Quelling pain has a good effect on the disease. If we use any drugs we could use morphin or cocain, fifteen grains of chloralamid at night, or fifteen grains of trional. The bowels should be kept open, then arrange something so that she will not move about too much. When the pain subsides and the active inflammation, we can use massage, and later electricity; and later, if the contractions are bad, we may have to operate on them. I think she should get well.

THE TREATMENT OF CHRONIC NON-SUPPURATIVE OTITIS MEDIA BY THE USE OF PILOCARPIN.

BY S. MACCUEN SMITH, M. D.

Very good results have been obtained from the use of the muriate of pilocarpin in sufficient doses to produce severe sweating in cases of chronic otitis media. Strychnin may be combined with this to avoid any untoward effect upon the heart. The pilocarpin should be given every other day until six or eight doses have been given. It is well to begin with one-sixteenth of a grain and increase this until a dose large enough to produce a profuse sweat is reached. One-sixth of a grain is usually sufficient. This treatment especially relieves the tinnitus which is such an annoying symptom.

If the strychnin is not used before giving the injection, a drachm of whisky in hot water is a good stimulant, and also aids in producing the sweat. Another aid in producing diaphoresis is a glass or two of ice water, taken immediately before the pilocarpin. In addition to these expedients wiping the body with a sponge wet with cold water aids in getting the full effects of the drug.

A case under the observation of one of the assistants showed a remarkable tolerance of pilocarpin, two-fifths of a grain being necessary to produce a copious sweat. One-sixth is usually large enough, and one-fourth is the largest I have ever employed.

Communication.

TO THE MEMBERS OF THE MEDICAL PROFESSION IN THE UNITED STATES.

The cause of humanity and of scientific progress is seriously menaced. Senator Gallinger has again introduced into Congress the bill for the "Further Prevention of Cruelty of Animals in the District of Columbia," which he has so strenuously and misguidedly advocated in the last two Congresses. It is Senate Bill No. 34. Twice the Committee on the District of Columbia has, also unfortunately and misguidedly, reported the bill with a favorable consideration. It is speciously drawn to seem as if it were intended only in the interest of prevention of cruelty to animals, but the real object is two-fold: 1, to prohibit vivisection, and, 2, to aid the passage of similar bills in all the State Legislatures.

It hardly needs to be pointed out that this would seriously interfere with or even absolutely stop the experimental work of the Bureau of Animal Industry and the three medical departments of the Government, the Army, the Navy, and the Marine Hospital Service. The animals themselves might well cry out to be saved from their friends. No more humane work can be done than to discover the means of the prevention of diseases which have ravaged our flocks and herds. All those who raise or own animals, such as horses, cattle, sheep, pigs, chickens, etc., are vitally interested in the preservation of their health and the prevention of disease.

The inestimable value of these scientific researches as to the prevention and care of disease among human beings it is superfluous to point out. Modern surgery and the antitoxin treatment of diphtheria alone would justify all the vivisection ever done.

As my attention has been called officially to the introduction of the bill, I take the opportunity of appealing to the entire profession of the country to exert itself to the utmost to defeat this most cruel and inhuman effort to promote human and animal misery and death and to restrict scientific research. It is of the utmost importance that *every physician* who shall read this appeal shall *immediately* communicate especially with the Senators from his State, shall also invoke the aid of the representatives from his or other districts in his State, and by vigorous personal efforts shall aid in defeating the bill.

It is especially requested also that all of the national, State and county societies, at their next meeting, take action looking toward the same end. If regular meetings are not soon to be held, special meetings should be called. Correspondence is invited from all those who can give any aid.

The committee on the District of Columbia consists of Senator James McMillan, Michigan, chairman, and Senators J. H. Gallinger, New Hampshire; H. C. Hansborough, North Dakota; R. Redfield Proctor, Vermont; J. C. Pritchard, North Carolina; Lucien Baker, Kansas; C. P. Wetmore, Rhode Island; C. J. Faulkner, West Virginia; Thomas S. Martin, Virginia; Wm. M. Stewart, Nevada, and Richard Kenny, Delaware. Personal letters may be addressed to them or to other Senators. Petitions should be addressed to the Senate of the United States.

W. W. Keen, M. D.,
President American Medical Association.

THE PROSSER CASE ENDED.

New Orleans, January 17, 1900.

Editors New Orleans Medical and Surgical Journal—In several recent issues of your journal, there have been inquiries concerning the work being done by the Louisiana State Board of Medical Examiners, with special reference to the prosecution of violators of the medical law in the parish of Orleans. I desire to give a resumé of the legal proceedings of the "Abbo," or S. S. Prosser case, which has occupied the attention of the Board for six or eight months and was finally settled three weeks ago.

Several weeks before the meeting of the board in May, 1899, Dr. S. S. Prosser, a graduate of the Jefferson Medical College, applied and obtained a temporary certificate to practice medicine in Louisiana until the regular meeting of the board. On the day the board met in session, Dr. Prosser did not present himself until the examination had been in progress four or five hours. It being impossible for him to stand the examination in such a limited time, he was told that his temporary certificate had expired and it would be a violation of the law to continue practicing until he had obtained another certificate. Evidence having been obtained, he was enjoined from practicing in Louisiana by the United States Court. This injunction was issued the day before Judge Parlange left for his summer vacation. A letter giving the details of these proceedings was published in last month's issue of your journal, also giving the cause of the board's apparent delay in not pushing this case to a close during the summer months. In November, a few days after Judge Parlange's return, the case was taken up, and Dr. Prosser was fined for contempt of court for disregarding the injunction which had been issued against him some months before. Dr. Prosser came before the board in December, 1899, but did not obtain a certificate. A few days afterwards, he got out a mandamus to try to force the board to issue him a certificate to practice, claiming the board was biased and prejudiced against him, because he advertised in the daily press. When these proceedings came up for trial, Judge Rightor was too ill to hold court, and the proceedings were continued indefinitely. The next week I received a letter from the board's attorney, Mr. E. T. Florance, as follows:

Dr. H. S. Cocram, President State Board Medical Examiners:

Dear Sir—I have the honor to inform you that S. S. Prosser has left the city in consequence of the proceeding taken by your board against him. He has abandoned his suit against the board in the State Court. The proceedings in the United States Court will hereafter be merely formal, so as to make perpetual the injunction already issued.

Yours very truly,

E. T. Florance.

Seeing the advertisements in the morning papers of the "Abbo Medical Institute," and knowing Dr. Prosser had left the State, I wrote to the institution, asking to be informed who was at the head of it, and doing the practicing. A Dr. Brisbane called at my office and said that he alone was conducting the affairs of the

Abbo Medical Institution, and that Dr. Prosser had not been in the State for several weeks.

Dr. Brisbane's name appears on the official list of registered physicians of this State.

Yours truly,
H. S. Cocram, M. D., *President.*

STATISTICS WANTED.

Notice.—The Journal has received the following self-explanatory request:

Gentlemen—I am desirous of collecting all available statistics on cases of abdominal section for gunshot wounds of the abdomen. Answers, as complete as possible, to the following are requested:

1. What organs were injured?
2. How long between injury and operation?
3. Result.

W. E. Parker, M. D.,
124 Baronne street, New Orleans.

Exchanges will please copy.

NOTICE.

All titles of papers to be read at the coming meeting of the Louisiana State Medical Society in April should be sent by March 15, to the chairman of the Committee of Arrangements, Dr. Isadore Dyer, 124 Baronne street, New Orleans.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

A MENACE TO MEDICAL ADVANCE.

Almost with the dawn of the new century, while the review of the last is yet incomplete, the medical profession is threatened in a vital part of its work. At every turn of the wheel of progress some obstacle is met. Formerly ignorance dictated the obstruction, and even to-day this is largely evident.

The poseurs of moral guardianship now and then essay another role in their relation to humanity, according to the degree of the insane wave which starts their brain cells into activity.

Hypercritic at first, without being informed, the self-opinionated victims of the obstructionist idea have come to believe that the mass of the people have grown along with them. God save the mark!

We as intelligent citizens of the civilized globe know how much vivisection and the use of animals for laboratory experimentation have helped our knowledge of the human kind, in health, as well as in disease.

The Gallinger bill, referred to in another part of this number of the Journal, aims at the paralyzing of experimental medicine in this country, while it ostensibly appeals to the maudlin sympathy of a public, fickle as a spring breeze.

Such sentimentalism, however, grows into a morbid force, and backed by political influence it may be easy for the champions (?) of antivivisection to force a bill through Congress, while the lack of opposition would imply an acquiescence on the part of the silent profession.

Dr. Keen, the president of the American Medical Association, in the circular appeal published in this number of the Journal has expressed fully the necessity for action, why and how action should be taken, and we trust that our word may add another stimulus.

THE STATE BOARD OF MEDICAL EXAMINERS AND THE PROSSER CASE.

The Board has successfully ousted the soi-disant "Abbo" and has perpetually enjoined Prosser from practicing in the State of Louisiana. The JOURNAL has from time to time reflected upon the Board, and feels that now credit is due and should be given for the successful issue of the legal proceedings in the case. It yet remains for that Board to bury the name of Abbo, by instituting the necessary measures to stop his successor in practicing under the same false title.

THE LOUISIANA STATE MEDICAL SOCIETY MEETING.

The State Society will meet in New Orleans April 19, 20, and 21. Very shortly a preliminary program will be issued calling upon the chairmen of sections to stimulate the interest necessary to a successful meeting. There are a number of matters for consideration aside from the usual interesting medical discussions, so we trust that the profession throughout the State will arrange to be present at what should be a good meeting.

PROPOSED INVESTIGATION OF THE NATIVE DRUG PLANTS OF THE UNITED STATES.

In his annual report the Secretary of Agriculture, the Hon. James Wilson, has embraced the following facts and recommendations which, in some particulars, are of interest to the medical profession:

"The collection of native drug plants in the United States, considered from a purely financial standpoint, aside from medical and humanitarian aspects, involves the expenditure of millions of dollars annually. The commercial extermination of some of the most useful species is already threatened, and doubtless would be found in the same conditions were the facts known. The price of one native plant, gingseng, our exports of which average more than a million dollars annually, has more than quadrupled in the past thirty years, so that its cultivation, as urged four years ago by this department, has now become profitable. It is clear from this and many similiar cases that the native industry is capable of either decline or improvement, according to the way in which we handle it.

"The Pan-American Medical Congress has recently submitted to me a proposition to co-operate with this department in a technic and statistic investigation and classification of our native drug plants. By accepting this proposal we shall secure, in a research of which we have long felt the need, the cordial assistance and support of an influential association of learned physicians; we shall encourage each of the other American nations, all of which are represented in the Pan-American Congress, to proceed with a similar investigation of their own medical flora; we shall furnish a basis for the remunerative employment of much land and many people, and we shall stimulate the great growth and growing trade in drugs between the countries of North America and South America. I urge the appropriation of $10,000 to enable this department to co-operate in this investigation."

With the commercial side of the question we are concerned only as good citizens, yet that should be sufficient to enlist our interest; possessing the soil and climate we do in Louisiana it is quite likely that proper study and investigation would show the possibility of the profitable production of drug plants which can not be cultivated in other sections of this country; and surely Louisiana and surrounding states would be benefited by an increased diversity of crops.

As physicians we are deeply interested in augmenting our supply of perfectly fresh medicinal plants whose purity and quality could then be more particularly ascertained and controlled. Their prices could be more easily kept within bounds and those of moderate means be advantaged.

We should, therefore, endorse the recommendation of the Secretary of Agriculture and urge our Congressmen to assist in obtaining the appropriation required.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER,
New Orleans, La.

THE CAUSE OF ECLAMPSIA AND THE DIAGNOSIS OF IMPENDING ECLAMPSIA.—Dr. E. A. Davis (*the Amer. Gyn. and Obst. Journ.*, July, 1899) believes that the weight of evidence is distinctly in favor of the belief that a profound toxemia orginating within the bodies of the mother and father is the cause of eclampsia. The post-mortem changes are degeneration of cell protoplasm in the liver, mainly around the central vein of each lobule, degeneration of the epithelium of the convoluted tubules of the kidneys and hemorrhages in the placenta. Special stress is laid upon the importance of the liver in this connection. For positive evidence in favor of the toxemic theory we should naturally look to the blood and urine of the eclamptic patient. The urine of eclamptics is only feebly toxic when injected into animals, while the urine of healthy individuals is often highly toxic. This is due to the retention in the blood serum of the toxins of eclampsia. If the urine were toxic the patient would get rid of the poison and would not be intoxicated. The serum of eclamptics is highly poisonous to animals. It is difficult to obtain the serum of patients threatened with eclampsia for examination, nor is it easy to determine the toxicity of the urine, but we have in urea a body which serves as a sort of clinical index to the metabolism of the body. Though not itself a poison, its excretion corresponds to that of the poisons concerned, and diminution in the quantity of urea excreted indicates that toxins are being retained. The pregnant patient rarely excretes a normal amount of urea, but less than 1.5 per cent. is suggestive of impending eclampsia. Some idea of the amount of solids excreted may be obtained by multiplying the last two figures of the specific gravity by 2.33. The presence of sediments calls for a microscopic examination.

Jaundice is an especially grave symptom and points to grave toxemia. The skin, intestine and lungs must receive full attention to ascertain the part they are playing in elimination. The nervous system is especially affected by the poison and is the most important medium of communication between the physician and patient. Neuralgia, indigestion, ptyalism, pruritis, pernicious nausea, insomnia, eruption upon the skin and excessive sweating have all been traced to this source. Melancholia and mania belong to the same train of symptoms.

THE TREATMENT OF PUERPERAL ECLAMPSIA.—The treatment of eclampsia is extensively discussed in the December number of *The Therapeutic Gazette.* Edward P. Davis and Richard C. Morris express a preference for chloroform for controlling the convulsions. Edward Reynolds advises immediate delivery under ether anesthesia in all cases in which one convulsion has occurred. He occasionally gives a single hypodermic injection of one-sixth grain of pilocarpin, and prefers chloral to morphin as a sedative. J. Clifton Edgar protests against the careless way in which the term "*accouchement forcé*" is used, and the easy confidence with which it has been recommended as the best, if not the only means of controlling eclamptic seizures, without attaching sufficient importance to the condition of the cervical barrier. Barton Cook Hirst (Text Book of Obstetrics) considers chloroform the only anesthetic to be employed. Its place in the treatment of eclampsia is now settled. No one would rely on it alone; but everyone is willing to admit its value as an adjunct to other treatment. The only emunctories available for quick and effectual elimination are the skin and bowels. In private practice the hot wet pack or the hot air bath are the most practicable methods for exciting diaphoresis. The injection of normal salt solution into the subcutaneous cellular tissue or under the breasts is an indispensable aid to free elimination by the skin. It seems literally to wash the blood of its impurities. Free catharsis is produced best by the use of croton oil, which may be administered in drop doses upon the back of the tongue, and can therefore be given to a woman whether she is able to swallow or not. Elaterium, in quarter-grain doses, rubbed up with butter, may be administered in the same manner.

Morphin is beneficial only in very heavy doses of the drug.

Veit has injected one-half grain in each convulsion seizure, and has administered as much as three grains in four to seven hours, and four and a half grains in twenty-four hours.

The use of veratrum viride is the American treatment of eclampsia. Pilocarpin is mentioned only to be condemned. There is no other treatment of eclampsia that gives so high a mortality.

In regard to obstetric treatment, Hirst believes it is better to avoid interference with the progress of labor, unless the os is fairly well dilated. Should eclampsia come on before labor begins at all, or in its earlier stages, the physician's attention should be confined to combating the convulsions. The advantages of *accouchement forcé* and deep multiple incision of the cervix, according to Dührssen's plan, have not yet been demonstrated and are not likely to be.

Venesection, while at present somewhat in disfavor, is a valuable procedure in cases of impending pulmonary edema and apoplexy. In appropriate cases it should be done in time, and not as recommended from some sources, only when symptoms of pulmonary edema appear. The measure is preventive of this accident, not creative.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Unrecognized Syphilis in an Infant; Infection of the Nurse; Multiple Chancres of the Breasts.—A healthy woman became wet-nurse to a premature infant eight days old, apparently well. Within three weeks the child showed all the symptoms of a severe congenital syphilis, and died a week later. Eight days after the baby's death the nurse had one chancre on the left breast and twenty-one ulcerating sores, indurated and round, on the right. In the right axilla the lymph nodes were indolently enlarged. The mouth and genitals were normal, and the woman never had any general eruption, but severe headaches at night and malaise. While chancres of the breast are usually multiple, it is rare to find them so numerous as in this case. The parents of the baby denied all history of syphilis, but the lesions in both child and nurse were unmistakable.—*Archives of Pediatrics*, December, 1899.

MECHANICAL TREATMENT OF PARALYSES.—Dr. Goldscheider (Society of Internal Medicine of Berlin, Dec. 18, 1899) presented a youth, 17 years old, who had been in the hospital since August, 1897, with a motor and sensitive paralysis of inferior limbs, the latter in a state of contracture, with also incontinence of urine. These functional troubles were due to Pott's disease, dating from years back; there indeed existed a gibbosity about the sixth dorsal vertebra. This patient had first gone through the operation of straightening the spine according to Calot's procedure, without any good result; he was then treated by extension and by production of movements of the limbs by means of the hands, his whole body being immersed in warm water.

After five months improvement began to show, and at present the patient can stand up unsupported, and walk alone during twenty minutes. Dr. Goldscheider has cured in a similar manner a young girl 16 years old, who had also a paraplegia with incontinence of urine, following Pott's disease of the eighth dorsal vertebra. These two cases show that treatment must not be abandoned, even though the paralysis is of long standing, for the spinal cord may suffer compression for a long time without its elements being destroyed, the fact is positively true. A circumstance, or rather a fact, which is not so commonly heard of, is that contractures of some time standing can possibly be made to disappear under extension and manipulations exhibiting passive movements. The method promotes at times, it is true, an increase of the troubles, either by way of a reflex or by the production of some exudation in the vertebral canal, but nevertheless the treatment must be persisted in and the measures used continually.

Paralyses of central origin are not the only ones amenable to the mechanical treatment indicated here, for the latter is just as beneficial in peripheric paralysis of either the superior or inferior limbs.

Kinesitherapy is also efficacious in the lightning pains of tabes, in sciatic neuralgia, etc. It is a valuable method, just as valuable as the physical agencies we daily use in practice: applications of cold, heat, electricity, air-cure, etc.—*Gaz. hebdom.*, January 4, 1900.

TUBERCULOSIS AND LIFE INSURANCE.—At the recent meeting of the First International Congress of Physicians of Life Insurance Companies at Brussels (September, 1899), there was a discussion upon the question of the insurability of tuberculous subjects. The paper on the subject was read by Dr. Meyer, of Metz, according to whose expressed views the examiner should reject the following classes of applicants:

1. Those who have, or have ever had, a presumably tuberculous coxalgia, otitis, osseous caries.
2. Those of tuberculous stock who have ever had a pleurisy, hemoptysis, chronic bronchitis, scrofulous lesion, spinal deviation.
3. Those who (independent of ancestry) have ever had any form of pulmonary, bronchial or pleural affection of a tuberculous character.
4. Those dyspeptics of tuberculous stock who are refractory to all treatment.
5. Those of tuberculous stock who live under conditions which invite tuberculosis and who are naturally below normal in weight and in chest measure.
6. Those of tuberculous stock below the age of 35 (or 40) who have not a vigorous constitution.
7. Those who may be termed, in the widest sense of the word, fit candidates for tuberculosis.

On the other hand, a very robust and vigorous individual may be accepted even if he comes of tuberculous stock.

Discussion: Solomonsen would be guided largely by the weight in estimating the likelihood of an applicant's developing tuberculosis.

Wull-Mauton (Paris) would reject for traumatic hemoptysis, because this condition so often leads to pulmonary tuberculosis. Anal fistula ought invariably to reject the applicant.

Moritz, of St. Petersburg, would postpone for fistula in ano. Manillon, of Brussels, would be guided rather by the entire family history, and special diseased states would be considered by him from a subordinate point of view.

The statements of the last speaker are more in accord with the views of the American actuaries. A good family history, good weight, with freedom from suspicious disease for ten years, would lead to the acceptance of risks, despite a personal history of hemoptysis or numerous other conditions presumably of tuberculous nature, even including spondylites. As the mortality from tuberculosis is becoming smaller throughout civilized countries, it is difficult to understand the increased strictness of the rulings of Dr. Meyer, unless the latter are an outgrowth of the compulsory and co-operative factors which obtain so extensively in certain parts of the continent.—*The Journal of Tuberculosis,* January, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans, La.

Methylen Blue as a Sedative in Insanity.—Recent studies by P. Bodoni, of the University of Genoa (*Klinisch-therapeutische Wochenschrift*, No. 21, 1899, p. 666), seems to show wide applicability of this remedy as a sedative in excited mental states. He reports fourteen cases in which the remedy was tried; these include such conditions as simple acute mania, mania with furor, periodic mania, chronic mania and the mania of chronic alcoholism, periodic melancholia, paranoia with delirium, hystero-epilepsy and puerperal mania. In all of these cases the remedy was administered by hypodermic injection into the gluteal muscles, in amounts varying from one to one and one-half grains. Its sedative action became manifest within from three to six hours and usually persisted a day, or, in some of the cases, even for three to four days. The quieting action was not attended by any narcotic effect, and there were no unpleasant after symptoms observed.—*The Therapeutic Gazette.*

The Treatment of Whooping Cough.—The *Journal des Praticiens* of September 30, 1899, gives the following summary of the various methods which may be employed in the treatment of this affection. One method is that of Dutremblay. It consists in treating the disease by inhalations of oxygen gas saturated with medicated vapor. In a dilatation of the tube through which the oxygen gas passes is placed a piece of cotton, and this cotton is wet with equal parts of bromoform and cherry-laurel water. In other cases it is wet with a solution of bromated camphor.

Gilbert has suggested that whooping-cough be treated by antidiphtheritic serum, and claims that when this serum is injected as it would be for the cure of diphtheria it does good in whooping-cough, perhaps by producing leucocytosis. He claims that Cerioli, in an epidemic of whooping-cough, treated fifteen cases in this way with very satisfactory results in all except one. The dose injected was from five to ten cubic centimeters, but the strength of the antitoxin is not given.

A third way of treating the disease is that of Legrand, who has found grindelia robusta a most efficient remedy in whooping-cough as well as in asthma. He believes that the powdered bark and its fluid extract are apt to be inactive, but that the tincture is useful, and that the alcoholic fluid extract is also valuable. He has usually administered the fluid extract in sugared water or milk, although there is always a certain amount of resinous material precipitated in the vessel from which the child takes the dose. This may, to a certain extent, be avoided by adding to the milk a little glycerin and alcohol. Children should take eight minims of the extract every few hours, according to the effect produced.—*The Therapeutic Gazette.*

A STOMACHIC.—*Riforma Medica* for September 7 gives the following:

Hydrochloride of orexin	30 grains.
Extract of gentian and powdered althea root, enough for	20 powders.

M. Divide into twenty powders and give from one to two daily in a cup of meat broth.

—*New York Medical Journal.*

THE USE OF QUININ IN MALARIAL HEMOGLOBINURIA.—Steggall, of Costa Rica (*Medical Record*, Aug. 19, 1899), has reached the following conclusions upon this subject: (1) Quinin causes irritability of the kidneys and may cause hemoglobinuria. (2) Malarial attacks in chronic cases with malarial cachexia may cause hemoglobinuria. (3) In these cases quinin has lost much of its specific effect, and large dose must be exhibited. Should there be a periodicity, we must give the quinin before the attack. (4) The action of quinin should be assisted by such drugs as iron and arsenic, and, more important than quinin, the liver must be acted on well, and the effect kept up. Dr. Steggall says he has never been able to cure an attack of hemoglobinuria without getting the liver active; the bilious vomiting in these cases sufficiently indicates the necessity of this.—*The Therapeutic Gazette.*

BROMIDE OF CAMPHOR IN EPILEPSY.—Haslé (*British Medical Journal,* Aug. 5, 1899), after carefully selecting a number of cases of epilepsy from the abundant material at Bicêtre, obtained the following very constant results: (1) As regards epilepsy proper (*haut mal*), the action of bromide of camphor was doubtful, and was less effectual than the mixed bromides of potassium and sodium and ammonia. (2) In attacks of *petit mal,* and in all cases of epileptic vertigo, however, its effect was incontestable; it at first diminished the frequency of the vertiginous attacks, and finally made them disappear altogether. The condition to be observed in prescribing was to begin with moderate doses, made gradually progressive and lasting for a sufficient time. Owing to its disagreeable odor it is best to take it in capsules of 20 centigrams, or dragées of 10 centigrams, beginning with two capsules per diem, and augmenting by two capsules the second week, etc., till eight capsules per diem are taken, then as gradually diminishing the dose till two capsules per diem are reached and maintained for some time.

FOR HEADACHE.—The following list of prescriptions for headaches of various kinds is taken from *Merck's Archives:*

Headache from Oophoritis:

Ammonium Bromide	6 drs.
Fluid Ext. Hydrastis	4 fl. drs.
Tinct. Gentian Compound	12 fl. drs.
Water	to make 6 fl. ozs.

Dessertspoonful three times a day.—SINKLER. *Phil. Med. Journal.*

Gouty Headache

Potassium Carbonate	99 grs.
Ammonium Carbonate	1 dr.
Tincture Serpentaria	4 fl. dr.
Camphor Water	to make 4 fl. ozs.

Add 1 fl. oz. to ½ fl. oz. each of water and lemon juice. and take two or three times a day, while effervescing.—*Med. Record.*

Hemicrania with Contraction of Pupil:

Caffein Citrate Menthol	of each 3 grs.
Quinin Sulphate	6 grs.

Make four powders and give one every two hours.—*Clinica Moderna.*

Sleepy Headache:

Sodium Bromide	1 dr.
Phenacetin	30 grs.
Caffein Citrate	18 grs.
Sodium Bicarbonate	1 dr.

Make six powders and give one every fifteen minutes till relieved. Follow with a Seidlitz powder.—STALLER, *Medical Record.*

Hemicrania:

Caffein	6 grs.
Cocain hydrochloride	3 grs.
Antipyrin	75 grs.
Potassium bromide	75 grs.
Powdered guarana	45 grs.

Make ten powders and give one as required.

—ROBIN, *Riforma Medica.*

Hemicrania:

Quinin valerianate	30 grs.
Caffein Citrate	15 grs.
Ext. Indian hemp	3 grs.

Make twenty pills and give two or three during the day.

—Quebec *Revue Médicale.*

Uremic Headache:

Potassium citrate	2 drs.
Spirits juniper	6 fl. drs.
Sweet spirits nitre	2 fl. drs.
Infusion broom tops	6 fl. ozs.

Wineglassful three times a day.—*Practical Medicine.*

Gouty Headache:

Quinin valerianate	15 grs.
Ext colchicum	4 grs.
Ext. digitalis	4 grs.
Ext. aconite	2 grs.

Make ten pills and give one at night and after dinner.

—HIRTZ, *Med. Record.*

Migrain:

Menthol valerianate	75 grs.
Syrup adiantum (Maidenhair)	1 fl. oz.
Distilled water	6 fl. oz.

Fiften drops to be taken twice in an hour.—FRAISER, *Munch. Med. Wochensch.*

Neuralgic Headache:

Quinin sulphate	48 grs.
Ext. hyoscyamus	6 grs.

Make twelve capsules and give one every four hours.—*New Eng. Med. Monthly.*

Nervous Headache:

Diluted nitro-hydrochloric acid	2 fl. dr.
Strychnin sulphate	½ gr.
Spirits chloroform	6 fl dr.
Tincture ginger	3 fl. dr.
Water	to make 3 fl. oz.

One teaspoonful in water three times a day.—*Gaillard's Med. Jour.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King,
New Orleans.

Etiology and Treatment of Certain Vocal Troubles.—Among the recent publications of the "*Institut de Laryngologie et d'Orthophonie*," of Paris, under the direction of Dr. Marcel Natier, appears an interesting study by Dr. Paul Olivier, of a vocal alteration, which, though somewhat obscure in its pathogeny, corresponds, however, with a well-defined clinical entity.

The writer has in view such modifications of the voice, without paralysis, of doubtful origin called in turn nervous dysphonia, transitory dysphonia, vocal asynergia, mogiphonia, and usually classified under the name of paresis of the vocal cords. He eliminates, naturally, all vocal disorders due to general or organic diseases, taking care also to avoid a confusion with hysteric, reflex and spastic aphoniae.

The patients of this class will generally exhibit the following phenomena: Be they tragedians, having failed for some time past to maintain the proper vocal power, the voice becomes muffled, especially at the end of those sentences which should prove the most effective. If comedians, they quickly get out of breath. As singers, they must give up this means of livelihood, or of distraction, because of their inability to maintain the note or to draw it out.

The singing voice is discordant, whereas the speaking voice may be but slightly altered; the reverse may also be observed, the speaking voice being hoarse. The singing voice may remain clear enough; the high notes only become impossible.

These symptoms are oftener met with in persons who make much use of their voice, especially in women. Persons of ordinary avocation are also found with a false, disagreeable, piercing voice, which has become of considerable annoyance to them, but which they and their surrounding family have accepted, believing that no relief can be had.

An examination of the larynx shows a normal appearance; its mucous membrane is neither red nor inflamed; the vocal cords move well during respiration. The emission of the vowel *E* fails to bring the cords in close apposition, leaving between them in their length a more or less narrow chink, or again the intercartilaginous glottis may remain open as in the case of an isolated paralysis of the ary-arytenoidei muscles. If the cords happen to finally approximate closely they are observed to soon give way under the pressure of the expired air which escapes too rapidly.

Following this descriptive exposé the author reviews at considerable length and with much clearness the opinions of various writers as far back as 1822. With some of these Dr. Olivier is inclined to attribute these peculiar vocal disorders to an impoverished condition of the general health, the cause of which is to be found in a disordered digestion and assimilation, and in an imperfect oxidation of the blood in the lungs. He lays great stress on the latter condition, which is intimately associated with a diminished vital pulmonary capacity and with a defective or faulty respiration. The experiments of Piltan and, later, of the Abbé Rousselot, at the "College de France," have abundently demonstrated the influence of respiration on voice production; the latter has been able to demonstrate, with an improved pneumograph, in a series of tracés, and, with the spirometer, the defects of the respiratory acts, etiologic factors in most of these cases of dysphonia *sine materia*. A treatment based on respiratory gymnastics and vocal exercise has proven to be eminently successful. As a proof of its efficacy the author reports eight cases which were cured more or less rapidly by this method. An idea of the nature of the respiratory exercises to which these patients were submitted can be obtained from a report of one of his cases in which he writes: "In prompting this young girl to talk one notices at once that her tendency is to speak rapidly, scarcely breathing between her sentences; when her attention is called to this particular defect she observes herself closely and manages to take a deep inspiration, but allows the escape of a large quantity of expired air before emitting a sound. This is evidently a case of nervous dysphonia, in which the larynx being normal the trouble must be traced to a faulty respiration. After positive assurance of a certain recovery I teach the patient to breathe naturally and noiselessly; then she is made to pronounce vowels, the emission of which is sudden and follows a deep inspiration; this exercise is repeated until good results are obtained. She is next made to read with the same precaution, and it is not more than ten minutes before the desired end is achieved, the voice having been restored to its normal condition.

"With the laryngeal mirror the cords are now seen to come into close apposition. Twelve days after the patient was still preserving a normal voice."

After protesting against the classification of these cases with those of hysteric origin, Dr. Olivier also wishes to differentiate them from certain dysphonic symptoms connected with the early and even pre-tubercular stage of pulmonary consumption. In conclusion, the author states that certain vocal disorders, the cause of which fails to be revealed by the closest examination at the hands of an expert, must be attributed to a lesion of a distant organ or to an unconscious diminution of the respiratory act. It is useless to hope much from ordinary local therapeutic measures; the treatment must consist mainly in hygienic measures, in proper attention to any disorder of a distant organ especially connected with the digestive tract, and lastly but not least, in a close scientific scrutiny of the respiratory act with the object of modifying the same if faulty.

THE TONSILS AS PORTALS OF INFECTION.—Dr. Emil Mayer, in a recent article read before the New York County Medical Association has brought out some important statistics and other facts relative to the frequency with which some of the acute infectious diseases are associated with or follow upon attacks of acute tonsilitis. According to Hodenpyl, the tonsils themselves are not apt to be the portals of infection unless there is some denuding of the epithelium; but the tonsillar crypts can readily assume that role, as their epithelium is frequently destroyed.

The supra-tonsillar fossa is also spoken of as being often the primary seat of infection, the tonsils becoming secondarily involved and then the general system. Acute articular rheumatism, which is generally considered as an underlying cause of tonsillar inflammation, is here looked upon, and with no little reason, as being a sequel of that affection. Acute pericarditis complicating rheumatism may derive its infection as well directly from the infected tonsil, and a case has been reported by Charrin in which the patient died of acute endocarditis following closely an attack of nonscarlatinal tonsillitis. Dr. F. A. Packard recently reported five cases of the same affection which had been preceded by an attack of amygdaliis.

Du Mesnil de Rochmont mentions the following diseased conditions that may arise from tonsillar inflammations: Albuminuria, erythema, urticaria purpura, erysipelas, orchitis and oorphoritis, pleuro-pneumonia, strabismus and paraplegia, and also osteo-myelitis. To these must be added the cases heretofore mentioned, tuberculosis, pleurisy and pyemia.

Dr. Mayer himself reports an interesting case of endocarditis following tonsillar infection.

Granting these facts, the author insists upon the importance of regarding cases of tonsillitis and peri-tonsillitis as serious affections, and treating them energetically. For the former, he recommends rest in bed, and iron locally and internally. Peritonsillitis if seen within twenty-four hours after the onset may be aborted by the use of the following efficaceous remedy:

℞	Morphin sulphate	0.06
	Tinct. veratrium viride	4.0
	Water	126.

M. Sig. A teaspoonful every hour for three hours, then once in three hours.

An Osteo-plastic Mastoid Operation.—With the view of avoiding the disfiguring cicatrix which results as a rule, from operations upon the mastoid process, Kuester, of Marburg, has devised a new procedure, the success of which he demonstrates in a series of nine cases operated on by him. In eight of these cases, four of which were operated for cholesteatoma, two for tuberculosis and two for chronic suppurative otitis, a cure was obtained and no noticeable deformity was left, even where extensive destruction of the mastoid cells had taken place. On case died of a complicating cerebral abscess.

The operation is described as follows: An incision is made immediately behind the auricle beginning a little above the level of the meatus and carried down as low as the tip of the mastoid process, it is then carried backward to the posterior border of the mastoid and upward to the height of the meatus. In this way, an irregular U-shaped incision is made including the outlines of the mastoid bone. The periosteum is cut through and, by means of a chisel, the cortex of the bone is separated from the underlying cells and raised up with the skin and periosteum. The diseased cells are then curetted away and the operation is completed by replacing the osteo-cutaneous flap and suturing the wound. A small notch is cut in the lower border of the bone flap, however, and a strip of gauze inserted for drainage. This is removed after a few days and the wound allowed to close completely.

The method is simple enough, and may be of practical value in cases of chronic mastoid affections where a radical operation is called for and the question of avoiding the disfiguration concerns us, but evidently it can not be well practised in those cases where there is necrosis of the cortex or a subperiosteal abscess.

—*Centralblatt für Chirurgie.*

Miscellaneous.

Leprosy Treated With Calmette's Antivenomous Serum.—In the *Philadelphia Medical Journal*, of December 23, 1899, Dr. R. S. Woodson relates the following:

The treatment of leprosy with antivenomous serum was first introduced by Dr. Isadore Dyer, of New Orleans, La.,in 1897, to whom the credit of originality is due. A report of Dr. Dyer's work is contained in the October number of the New Orleans Medical and Surgical Journal, 1897. He deduced his premises from the fact that Carreau, of Jamaica, in 1892, had reported a case of leprosy, having been bitten by a serpent, in which there occurred a marked amelioration of tuberculous lesions in the course of recovery from the effects of the bite.

It occurred to Dyer that if such effects could be produced from the accidental inoculation of a non-lethal amount of snake-venom, much more could be expected from the systematic and judicious use of the modified and attenuated venom of Calmette.

Having secured a supply of the serum, he began his experiments upon a series of five cases with the result that "in four out of five of these cases there was marked improvement; in one, a practical disappearance of the lesions present and of other evidences. In only one case was there negative evidence; in this one the age and frailty of the patient must be considered." A recent review of Dyer's work states that "two of these cases were apparently cured, as both individuals were now engaged in their usual occupation, with no relapse or evidence of the disease." It is for the purpose of contributing to the support of the efficacy of this treatment that I publish the following case under my observation:

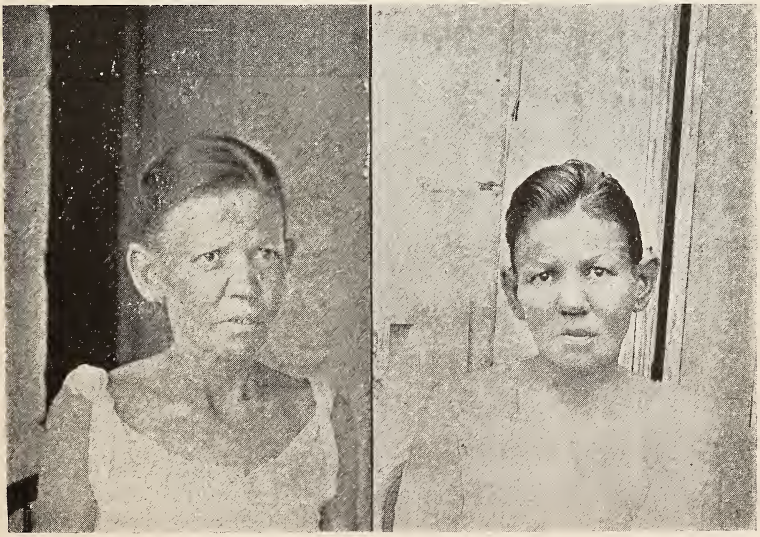
"Mrs. H.——, a native of Germany, though raised in this country from early childhood, a resident of Eagle Pass, Texas, aged 36, of large build, weight 131, no family history or history of contagion, was afflicted seven years past with a disease characterized by the following symptoms (her description of its inception): irregular fevers, loss of appetite, swimming in the head, headache, rheumatism of extremities and joints (later), the appearance of lumps in her skin, cold in the head, and finally loss of sensation principally in her hands and arms. She was treated six years for constitutional syphilis, during which time she lived in intimate contact with her family and friends, and as man and wife with her husband. Her youngest child was born two years after the appearance of the disease. None of her family show any evidence of infection."

The disease was not recognized until a few months ago, when Professor Smith, of Galveston, and I independently made a careful microscopic diagnosis of the case, as well as clinical, as follows, which was approximately her condition upon commencement of treatment, August, 1899:

A large, raw-boned woman of "scrawny" type, aged 36, but apparently 48; weight 131; hunted, down-cast look: duskiness of face, with marked telangiectasis extending over nose, cheeks, chin, and ears; nasal septum destroyed; nose lobulated and sunken in; infiltration of sides of nose extending into cheeks; supraorbital infiltration a symptom-complex, giving the leonine expression of countenance; right ear leathery, pendulous and thickened; edema of the feet and legs, several small ulcers on each leg; numerous scars of past lesions; voice harsh and strident; stiffened fingers; anesthesia absolute along the ulnar tract, but sensation diminished over entire surface of arms, chest and back; very much mottled from former lesions; several small nodules along the dorsum of each hand, and on each forearm; marked muscular atrophy of both arms; abundant nasal secretion; frequent bleeding from venules on surface of nose; mental condition good, except for moments of violent rage on slight provocation.

"The patient stated that she was afflicted with the habit of frequently dropping objects held in her grasp; that her sense of touch was so deficient that she would need ocular demonstration of the fact that she held the object in her grasp; also that of late she could not feel the bite of insects (mosquitos) on any portion of her body. I enucleated a tubercle from the back of her hand about the size of a pea; she gave no evidence of pain during the operation."

I made smear-preparations from secretions of her nose and from bleeding capillaries of nose. The sections made from the



August 1, 1899. October 16, 1899.

Pictures showing patient before and after treatment.

tubercle gave the characteristic leprosy-structure. The leprosy-cells were numerous, a few bacilli were observed in the matrix of the nodule, but none were demonstrable in the cells themselves. The stained preparations of blood and nasal secretion both exhibited a small rod-bacillus, which resembled the organism observed in the stained section. In order that the question of diagnosis should be cleared of all doubt, the husband requested me to take her to Dr. Dyer, of New Orleans, for its confirmation. Dyer, after a careful examination, confirmed the diagnosis and recommended serum-therapy, which had already been determined upon. A supply of 56 bottles (10 *c. c.* each) of serum was obtained from the Pasteur Institute, and the treatment was commenced August 19, 1899.

The serum was administered subcutaneously by means of a Pravaz syringe, as a rule, in the interscapular region, the loose tissue below the margin of the ribs and in selected regions. The dose varied from 33 *c. c.* at first to 20 *c. c.* towards the close of treatment. In addition to the serum the patient was kept on large doses of hoang-nan during the entire treatment. Great care was observed in the sterilization of needles and syringes. The patient was placed in as perfect hygienic condition as possible.

Very little reaction was noticed during the first week. Each injection of from 3 to 6 *c. c.* was followed by a slight elevation of temperature, which gradually ascended with dosage increasing 0.3 *c. c.*, until on the ninth day it had reached 101° F. During this period patient suffered from headache and malaise. On August 26 patient stated that she thought her anesthesia of extremities was disappearing. From August 27 until September 1, successive crops of numerous tubercles appeared upon arms, forearms, hands, neck and back. They seemed to appear just under the surface, then to effloresce upon the surface, and in a few days to disappear. At this time numerous local injections were made in selected tubercles with the effect that in nearly every case the tubercles would rapidly disappear. On August 28 the dose was diminished to 5 *c. c.*, and on the 30th the injection was omitted, with the effect that the temperature dropped steadily back to normal on the 31st. Again, ascending doses were followed by gradual elevation of temperature, pulse and respiration from September 1 to September 4, so that owing to untoward symptoms the treatment was discontinued from September 5 to 11, when again temperature, pulse and respiration regained the normal. During this period patient was confined to her bed, with what appeared to be a diffuse cellulitis, with an erysipelatous eruption over entire back, shoulders and chest, edema of the hands and feet, peripheral neuritis marked in all extremities; temperature reaching 102° F.; pulse 132; respiration 26; abundant nasal secretion

On September 11 patient had improved very much, when the treatment was resumed, 10 *c. c.* daily. All untoward symptoms had disappeared, all tubercles had disappeared except two large ones, size of a filbert, situated one over the right scapula, one on left side, level of fifth rib. Frequent injections from this time on were made in individual lesions. On September 20, injection (2 *c. c.*) was made with small syringe into the infiltration of face. The result was alarming. The entire face became edematous beyond recognition in a few hours, lasting several days, but finally subsiding, leaving face much improved. On September 25 and after, daily doses of 20 *c. c.* were used until October 16, when supply of serum was exhausted. During the last three weeks of treatment the patient continued steadily to improve without exhibiting any marked reaction to the large daily doses (20 *c. c.*)

The patient was under my observation from July 17, 1899, to October 17, 1899. She was treated by serumtherapy from August 19 to October 17, in which time 500 *c. c.* of serum were used in forty-seven injections, maximum injection, 20 *c. c.* minimum 2 *c. c.*

The present condition of the patient is one of great improvement. She has lost the leprous expression. The supraorbital infiltration has disappeared. The infiltration on each side of nose, and that over each cheek has diminished perceptibly; in fact all of her face and ears there is a marked loss of infiltration.

The bluish color of her face has changed to a healthy red. The telangiectasis has diminished. Her eyes are clear and bright. There are no sores on any portion of her body. There is only one tubercle remaining (the one mentioned above on left side, level of fifth rib); this has proved somewhat obstinate despite frequent local injections. Her anesthesia has disappeared so that the injections have become extremely painful even along the ulnar tract. Her skin has become softer and fairer. Her chest and back have particularly improved, having filled out with healthy tissue, and all lesions have disappeared. Her nasal discharge has ceased. Her voice is natural and her fingers have lost their stiffness. She gained fourteen pounds in weight in 145 pounds. Her general health is excellent. The change in her personal appearance is best seen from the photographs before and after treatment.

In conclusion I will say that I do not as yet claim a cure for the treatment, which was suddenly interrupted, but the improvement argues a permanent cure in time.

[On account of Major Woodson's removal to the Philippines, the case has been placed under my care by mail advice. The improvement has continued under the serum, which has been kept up to date, January 10, 1900.—DYER.]

CHLORETONE, or tertiary trichlor-butyl alcohol, known also as anesin, aneson and acetone chloroform, is a hypnotic and anesthetic lately described by Dr. E. M. Houghton, of Detroit, Mich., and Dr. T. B. Aldrich, of Baltimore, Md. The formula is $HO.C(CH_3)_2CCl_3$. It is formed when caustic potash is slowly added to equal weights of chloroform and acetone.

It is a white, crystalline compound, having a camphoraceous odor and appearance; is sparingly soluble in cold water, more soluble in boiling water, and quite soluble in strong alcohol. Concentrated sulphuric acid decomposes it, while dilute acids and alkalies appear to have no effect upon it.

If chloretone is administered by the stomach, particularly if followed by considerable water, it passes rapidly and unchanged into the circulation and is distributed throughout the body Even after the administration of very large doses the spectroscope fails to show any effect on the hemoglobin of the blood. It lessens the pulse rate, but the heart is unaffected until the organism begins to suffer from a lack of oxygen. The main action of the drug is confined to the central nervous system, t being essentially the same as that of the other anesthetics and hypnotics of the fatty acid series, differing from most of the members of this group in not depressing the circulatory system. Chloretone, besides its central action, possesses local anesthetic properties in a marked degree, resembling cocain in many respects. Indeed, it will probably be found a useful substitute for the last-named drug, as the small amounts introduced subcutaneously to produce insensibility to pain in surgical work are entirely harmless.

Experiments seem to warrant the statement that chloretone has a selective action for the central nervous system, more chloretone having been found in the brain in several instances than in any other organ of the body.

Owing to the volatility of chloretone at ordinary temperatures, it was thought that it might be eliminated by the lungs, but careful experiments have failed to discover its presence in expired air. It has never yet been detected in the urine of animals even after large doses, nor has chloroform or acetone been found in such cases. It markedly increases the chlorides in the urine of dogs taking it, and the amount remains high for several days after its discontinuance. These facts seem to indicate that it is decomposed or burned down in the body.

It is too early, the authors claim, to prophesy what position chloretone will take in medicine, but the results as a hypnotic and local anesthetic are very encouraging. As high as sixty grains have been given at one time, without producing any untoward symptons. From six to twenty grains given in tablets at a single dose, followed by a drink of water or milk, seem to be quite sufficient to produce the desired results. Possibly the drug will prove to be a useful general anesthetic when administered in large doses: or it may be given before chloroform or ether and allow complete anesthesia to be produced by the use of a minimum amount of chloroform or ether. Perhaps such administration may prevent the annoying vomiting that so frequently occurs when a patient is being anesthetized.—*Merck's Archives.*

THE PRINCIPAL DIURETIC MEDICAMENTS.—Martz, of the Faculty of Medicine in Lyons, in *La France Médicale*, gives a number of prescriptions for diuretic purposes. Pills composed as follows:

Extract of convallaria, 1 grain;
Powdered convallaria, 1 grain.
Make in one pill, and give a pill night and morning.

Or a syrup made of:

Extract of convallaria, 4 drachms;
Syrup of bitter orange, 6 drachms.
A teaspoonful night and morning.

In other cases we may use:

Tincture of squill, 75 minims;
Syrup of bitter orange, 1 ounce;
Distilled water, 3 ounces.
One teaspoonful every few hours.

Or,

Extract of squill, 1 grain;
Powdered squill, 1 grain.
Make into one pill, and give one night and morning.

Or,

Theobromin, 7 grains.
Place in one cachet, and give four a day.

Or,

Caffein, 15 grains;
Benzoate of sodium, 30 grains;
Syrup of bitter orange, 1 ounce;
Water, 4 ounces.
This may all be taken in twenty-four hours.

Or again,

Powdered digitalis,
Powdered squill,
Powdered scammony, of each 1 grain.
Make into one pill, and give one such night and morning.

Or,

Carbonate of lithium, 7 grains;
Lemonade with carbonated water, 1 pint.
This to be drunk each day.

Or, by the bowel:

Nitrate of potassium, 30 grains;
Oxymel of squill, 6 drachms;
Milk, 3 ounces.
This to be given by the bowel.—*Therapeutic Gazette.*

THE OUTLINE TREATMENT OF MIGRAIN.—In *La Presse Médicale* of February 11, 1899, Gallois stated that in gouty migrain, depending upon uric acid, he believes that the constant use of large doses of bicarbonate of sodium is advisable, and directs the patient to take a saltspoonful of bicarbonate of sodium in each quart of water, which quantity shall be taken in each twenty-four hours. He states that three cases of inveterate migrain have been treated in this manner with excellent results.—*Ibid.*

A Sanatorium for Consumptives in Egypt.—In the paper on Climate in the Treatment of Tuberculosis, read by Sir Herman Weber at the International Congress in Berlin, and published in the *British Medical Journal* of June 3, that eminent physician said that both patients and the medical practitioners who send them to Egypt trust too much to the mere climate, and he mentioned that there were no sanatoria in that country. It appears, however, that Dr. A. J. Bently, formerly of Mena House, Cairo, had, before this complaint was uttered, taken steps to supply the want indicated by Sir Herman Weber. We learn that the commencement of next season will see the opening of a large sanatorium at Helouan, built and fitted on the latest principles. The palace of the late Khedive, situated in the northern and most elevated portion of the town, has been chosen for this sanatorium. It is completely open on all sides to the desert. The palace itself will be used chiefly for reception and consultation rooms, whilst an entirely new wing, so contrived as to catch the maximum of sunshine, is now in course of construction. This new wing will have three stories, and on the roof there is to be an exceptionally fine winter garden of some 800 square metres. According to present arrangements, the sanatorium will be capable of accommodating about seventy patients, and each room will be fitted according to the latest requirements, bath room, etc., being attached to every chamber. The windows are on the casement principle, with a pivoted ventilating glass reaching to the ceiling above the windows proper. This ensures constant air in the room, and practically patients while indoors will be living in open desert air.—*British Medical Journal.*

Accidental Wounds of the Female Bladder.—In a paper presented to the section on Obstetrics and Gynecology at the Columbus meeting of the American Medical Association (and published in the *Journal of the American Medical Association*), Dr. Wiggins, of New York, reports the following case:

M. H., unmarried, aet. 41, was suffering from a large myoma, which sprung from the anterior uterine wall and extended above the umbilicus. The abdomen was opened, and the tumor, which weighed seven pounds, was drawn through an incision of six inches and removed, together with the body of the uterus amputated near the internal os. As hemorrhage was profuse, it became necessary to remove the mass very rapidly, to accomplish which the anterior attachment of the tumor was clamped and cut, when it was discovered, from the escape of urine, that the bladder had been opened near the fundus.

The general cavity had previously been shut off with gauze pads and thoroughly irrigated, followed by the use of hydrozone in half strength, and this, in turn, by saline solution. The gauze pads were not changed, and the opening in the bladder, four inches in length, was closed by means of two layers of chromicized catgut sutures. The wound was then disinfected, and there being a large peritoneal flap, it was attached to the bladder and made to cover the line of sutures, thus making the bladder-wound extra peritoneal. After further washing out of the abdominal cavity with hydrozone and the saline solution the external wound was closed, without drainage, and the usual dressings applied. The patient being feeble it was not thought advisable to make a vesico-vaginal fistula to drain, but a self-retaining catheter was introduced. At the end of ten days, however, tumefaction occurred over the lower angle of the abdominal wound, and, on opening it, urine began to escape. A vesico-vaginal fistula was now made in order to afford adequate drainage. The sinus in the abdominal wall was curetted and, after being thoroughly disinfected with hydrozone, its walls were sutured. Soon afterward, the sinus having closed, the sutures which kept open the vesico-vaginal fistula were removed, and the latter closed quickly without any further operative interference.

Medical News Items.

The Orleans Parish Medical Society held its inaugural meeting on the evening of January 13. Quite a large gathering was present to welcome the incoming officers. The occasion was graced by the presence of the Chief Surgeon, Dr. Freymadl, of the German ship Moltke. Addresses were delivered by Dr. Dyer, as the retiring president, and Dr. Dabney, the incoming chief executive. Dr. John Callan was the orator of the occasion, his remarks being directed at the question of the physician's position in the community as a citizen. Refreshments followed the meeting, which adjourned at a late hour.

SMALL-POX has broken out in most of the large and small cities of the country. New Orleans, at this writing, has suffered with the rest. The local board of health, together with the medical profession, has instituted general vaccination, and by prompt isolation of the cases as they occur it is believed that the spread of the disease will be limited. At the present writing it has already much decreased.

AN INTERNATIONAL CONGRESS OF THE MEDICAL PRESS is projected to take place in Paris this year. The date has not yet been determined.

THE TRI-STATE MEDICAL ASSOCIATION OF THE CAROLINAS AND VIRGINIA will be held in Charleston, S. C., February 20, 1900. An excellent program is anticipated and a good meeting expected. The subject for the annual discussion will be on the negro, his sexual life and character, and the influence of his environments upon his social condition.

THE MEDAL OF THE AMERICAN MEDICAL ASSOCIATION has been revived and it will be given hereafter annually for meritorious scientific work. The committee for this year consists of Drs. George M. Gould, of Philadelphia; E. Fletcher Ingals, of Chicago, and T. W. Huntington, of Sacramento, California. The following rules govern the competition:

1. The medal shall contain the seal of the United States or a seal of the Association, to be hereafter designed, on one side and an Esculapian staff on the other, together with the name of the recipient of the medal and suitable inscriptions.

2. The commercial value of the medal shall be $100.

3. A standing committee on prize medals, consisting of three members of the Association, shall be elected by the Business Committee as follows: One for one year, one for two years and

one for three years, and thereafter one to be elected yearly to hold office until in either case his successor has been duly elected. In no case shall a member of the Business Committee hold a place on the Committee on Prize Medals.

4. The competing essays shall be typewritten or printed and shall bear no mark revealing their authorship; but instead of the name of the author, there shall appear on each essay a motto, and accompanying each essay shall be a sealed envelope containing the name of the author and bearing on its outer surface the motto of identification. No envelope is to be opened by the Committee until a decision has been reached as to the most deserving essay, and the other essays have been returned to their respective owners. The Committee shall have authority to reject and return all essays in case none have been found worthy of the Association medal. Competing essays must be in the hands of the Committee not later than March 1, 1900. For further information address any member thereof.

FORMER ARMY SURGEONS, NOW RETIRED, MAY NOT PRACTICE IN LOUISIANA without a State examination is the decision in a recent test case. Attorney General Cunningham has taken this position regarding one Dr. MacCammon, a former contract surgeon in the Army.

THE LEPER HOSPITAL, now located in Iberville parish, is considering removal to a point adjacent to the city of New Orleans. The appropriation of $20,000 made by the last Legislature for the establishment of a permanent home is now available.

THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS have issued a preliminary program of the fifth meeting, to be held in Washington, D. C., May 1, 2, 3, 1900. The sessions will be held in the Lafayette Square Opera House, and the Congress will be opened with a series of papers on the subject of bacteriology in health and disease. The list of contributors already given promises a valuable and successful convention.

THE JOURNAL acknowledges the many courteous felicitations for the New Year which have been received from its subscribers, exchanges and advertisers.

REMOVALS.—Dr. W. S. Bickham, formerly resident in New Orleans, is located at 922 Madison avenue, New York, after some years of research and study in European centers.

Dr. Oscar Dowling, at one time resident surgeon of the Eye, Ear, Nose and Throat Hospital, this city, has removed from Mobile, Ala., to Shreveport, La.

Dr. J. P. Runyan is now located at Second and Louisiana streets, Little Rock, Ark., to which point he has removed from Pine Bluff.

PERSONAL.—Dr. S. P. Delaup and Dr. John F. Oechsner, both of New Orleans, have joined the Benedicts during the past month.

Dr. WILLIAM A. HAMMOND died in Washington early in January. His career has been detailed in the lay and medical press. Perhaps the strongest argument for ethics in medical practice has been demonstrated by the decline and fall of this eminent, notorious and successful, but ostracised member of the medical profession.

THE MARYLAND MEDICAL JOURNAL has changed its publication from a weekly to a monthly issue. Its first appearance in its January number certainly promises a creditable future.

THE PROVIDENCE MEDICAL JOURNAL is a monthly edited and published by the Providence Medical Association. Its first number contains several interesting articles, while the style of the Journal commends it.

CHARITY HOSPITAL NOTES.—Dr. S. F. Mioton has resigned the position as assistant pathologist to accept the office of assistant city coroner. Dr. M. Couret succeeds Dr. Mioton as assistant pathologist. For December the hospital records the care of 1234 indoor patients and an outdoor consultation of 3654. The mortality was 7 per cent.

TUA-TUA AND RED MANGROVE ROOT are two new herbaceous remedies suggested as curative for leprosy. The former is under investigation by the Marine Hospital Service and the Smithsonian Institute at Washington; the latter as yet is only a commercial product.

A PRESS BUILDING FOR PUBLICATIONS OF THE UNITED STATES is to be erected on the exposition grounds in Paris. There is to be an exhibit hall in which will be examples of

American machinery for printing, and in addition there will be an exhibit of all kinds of publications in this country, lay and professional. The JOURNAL will be represented.

THE ILLINOIS STATE BOARD OF HEALTH has adopted a resolution under the provision of which reciprocity of State license is acknowledged. The requirements entailed provide evidence of sufficient examination and pre-requisite graduation from a recognized college.

THE PROGRESSIVE UNION of New Orleans, a composite citizen body, recently called a meeting inviting physicians to be present. Nothing tangible was accomplished, but the meeting promised for the future a much better understanding between the commercial bodies and medical men.

AN EXHIBIT OF PATHOLOGIC SPECIMENS, ETC., IS CONTEMPLATED in connection with the coming meeting of the American Medical Association at Atlantic City. The profession of the different States is to be represented through their respective medical societies. It is sincerly hoped that the profession throughout our State will take the deep interest which such an important and laudable undertaking deserves. Dr. Paul Gelpi, who has been appointed to collect specimens for the State of Louisiana, would be glad to correspond on the subject, solicits co-operation in making a collection which will reflect credit on the scientific spirit and advancement of the profession of Louisiana.

THE LOUISIANA STATE MEDICAL SOCIETY WILL HOLD ITS TWENTY-FIRST ANNUAL MEETING in New Orleans on Thursday, Friday and Saturday, April 19, 20 and 21, 1900.

The sessions will be held as usual at the Medical Department of Tulane, through the courtesy of the faculty of that institution.

A good meeting is anticipated, and every arrangement will be made for a large contingent from the districts outside of New Orleans. Railroad and hotel facilities will be duly looked after, and the meeting should be a large and successful one.

The president " earnestly hopes that the chairmen of the different sections will present an interesting and instructive series of papers representing their respective sections, and that all members of the Society should consider the fact that the Society can only be made a success by their constant exertion in its behalf and by their attendance at the annual meeting."

The officers and chairmen of sections for the current year are given below.

All communications regarding papers to be read, etc., should be addressed to the Chairman of the Committee of Arrangement, Dr. Isadore Dyer, 124 Baronne street, New Orleans.

General Medicine, Dr. J. A. Storck, New Orleans; *Surgery*, Dr. R. Matas, New Orleans; *Mental Diseases*, Dr. George A. B. Hays, Jackson; *Materia Medica*, Dr. F. J. Kearney, Plaquemine; *Diseases of Children*, Dr. E. M. Dupaquier, New Orleans; *Obstetrics und Gynecology*, Dr. P. Michinard, New Orleans; *Ophthalmology*, Dr. H. D. Bruns, New Orleans; *Otology, Laryngology vnd Rhinology*, Dr. A. W. de Roaldes, New Orleans; *Medical Jurisprudence*, Dr. A. L. Metz, New Orleans; *Dermatology*, Dr. Isadore Dyer, New Orleans; *Oral and Dental Surgery*, Dr. A. G. Friedrichs, New Orleans; *Quarantine*, Dr. F. J. Mayer, Opelousas; *Bacteriology*, Dr. P. E. Archinard, New Orleans; *Anatomy and Physiology*, Dr. S. P. Delaup, New Orleans; *Genito-Urinary Surgery*, Dr. Charles Chassaignac, New Orleans.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Text-Book of Diseases of Women, by CHARLES B. PENROSE, M. D., Ph. D., Professor of Gynecology, University of Pennsylvania. Illustrated. Third Edition, Revised. W. B. Saunders, Philadelphia, 1899.

Scarcely two years ago we had the pleasure of reviewing exhaustively the second edition of this work and then stated, as our opinion, that it was probably one of the very few desirable works on gynecology in the English language. This edition is practically similar to its predecessor, and for it we entertain the same high opinion. MICHINARD.

Essentials of Medical Chemistry, Organic and Inorganic. By LAWRENCE WOLFF, M. D. W. B. Saunders, Philadelphia, 1899.

Dr. Wolff is well known as a careful and conscientious chemist and his experience as a teacher of large bodies of medical students qualifies him in an eminent degree to set forth the subject in an easily comprehensible and abridged form. The work presents a brief but reliable outline of physiologic chemistry. The arrangement of the questions and answers of this manual are such as to conform to the principal text-books on the subject. STORCK.

The Urine and the Clinical Chemistry of the Gastric Contents, the Common Poisons, and Milk. By J. W. HOLLAND, M. D., Professor of Medical Chemistry and Toxicology, Jefferson Medical College of Philadelphia. P. Blakiston's Son & Co., Philadelphia, Pa., 1899.

The call for a sixth edition of this little manual indicates that it has proven a valuable syllabus for the laboratory. The size of the volume permits of it being carried in the pocket. Every second page is blank for memoranda, etc. Students will find this small volume reliable and convenient. STORCK.

A Laboratory Manual of Physiological Chemistry. By ELBERT W. ROCKWOOD, B. S., M. D., Professor of Chemistry and Toxicology in the University of Iowa. The F. A. Davis Co., Philadelphia, 1899.

This handy little manual will prove of much value to the medical student. In the arrangement of the work the use of expensive apparatus and reagents have been avoided as much as possible, thereby allowing the student to pursue his studies at home without much cost.

We most heartily agree with the author regarding the "superiority of the laboratory method of instruction over the didactic."

We welcome the book and commend it to beginners in physiologic chemistry. STORCK.

Transactions of the Louisiana State Medical Society, 1899, H. B. GESSNER, Secretary, New Orleans.

The transactions of the State Society are late in appearing, but this must be excused for the reason given by the publication committee which is that the stenographer did not deliver his report until October. The transactions are much smaller than usual owing to the failure in delivery of papers, many of which were read by the title.

Essentials of Diseases of the Skin. by HENRY W. STELWAGON, M. D., Ph. D., Clinical Professor of Dermatology in the Jefferson Medical College, etc. Fourth edition, illustrated. W. B. Saunders. Philadelphia, 1899.

This handy volume has reached its fourth edition. It is one of the series of students' compends issued by a well-known publisher, and it is all it pretends to be, a concise and comprehensive hand book on dermatology. DYER.

PUBLICATIONS RECEIVED.

Notes on the Modern Treatment of Fractures, by John B. Roberts, M. D.—D. Appleton & Co., New York, 1899.

Twentieth Century Practice of Medicine—Vol. XVIII, edited by Thomas L. Stedman, M. D.—William Wood & Co., New York, 1899.

A Practical Treatise on Materia Medica and Therapeutics, by Roberts Bartholow, M. D.—D. Appleton & Co., New York, 1899.

Bacteriology in Medicine and Surgery, by Wm. Hallock Park, M. D., and A. R. Guerard, M. D.—Lea Brothers & Co., New York and Philadelphia, 1899.

The Vital Statistics of Massachusetts for 1897, with a Life Table Based Upon the Experience of the Five-year Period, 1893–97, by Samuel W. Abbott, M. D.

A Practical Treatise on Medical Diagnosis, by John H. Musser, M. D.—Lea Brothers & Co., Philadelphia and New York, 1899.

Operative Surgery, by Joseph D. Bryant, M. D.—D. Appleton & Co., New York, 1899.

Refraction and How to Refract, by James Thornington, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

REPRINTS.

Sinus-Thrombosis—Prognosis of Laryngeal Tuberculosis, by Robt. Levy, M. D.

The Modern Use of Synthetics, by Reynold Webb Wilcox, M. D.

The Efficacy of Hydragogin, by Dr. K. Goldberg.

The Therapeutic Value of Kryofine, by Dr. Adolf Fasano.

List of Local Board and Bureaus of Health in Pennsylvania—Fifth Annual Meeting of the Associated Health Authorities of Pennnsylvania—State Board of Health.

Precautions to be Observed by Funeral Directors, Undertakers and Nurses in the Case of Those Who Have Died of Communicable (Contagious or Infectious) Diseases—Precautions against the Bubonic Plague—The Diagnosis of Small-Pox, State Board of Health of Pennsylvania.

Lessons from Two Hundred and Twenty-four Consecutive Abdominal Sections, by J. H. Carstens, M. D.

Some Practical Remarks on the Anatomy of the Temporal Bone, with Demonstrations, by Emil Amberg, M. D.

Observations and Reflections on Abdominal Surgery, by Prof. A. C. Bernays.

A Review of the History and Literature of Appendicitis, by George M Edebohls, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR DECEMBER, 1899.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	3	5	8
" " Intermittent			
" " Remittent			
" " Congestive	2		2
" " Typho	1	1	2
" Yellow			
" Typhoid or Enteric	19	10	29
" Puerperal	2		2
Influenza	3		3
Measles	12		12
Diphtheria	3	1	4
Whooping Cough			
Apoplexy	12	4	16
Congestion of Brain	4	6	10
Meningitis	7		7
Pneumonia	40	31	71
Bronchitis	17	4	21
Cancer	11	1	12
Consumption	39	35	74
Bright's Disease (Nephritis)	21	9	30
Uremia	1		1
Diarrhea (Enteritis)	20	5	25
Gastro-Enteritis	3		3
Dysentery	6	5	11
Hepatitis			
Hepatic Cirrhosis	8	2	10
Peritonitis	3		3
Debility, General		3	3
" Senile	15	17	32
" Infantile	5	6	11
Heart, Diseases of	38	13	51
Tetanus, Idiopathic			
" Traumatic	2		2
Trismus Nascentium	4	7	11
Injuries	14	12	26
Suicide	3	1	4
All Other Causes	93	39	132
TOTAL	411	217	628

Still-born Children—White, 31; colored, 10; total, 41.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 23.49; colored, 28.89; total, 25.12.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.13
Mean temperature	54.
Total precipitation	2.79 inches

Prevailing direction of wind, north.

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[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

ON THE ASSOCIATION OF PARALDEHYDE WITH CHLOROFORM. A NEW CONTRIBUTION TO STUDY OF MIXED ANESTHESIA.

BY DR. COSIMO NOTO, NEW ORLEANS.

The discovery of anesthetics has proven to be not only one of the best achievements of human ingenuity, in relieving patients of the pains attending them in surgical treatment, but, moreover, it has opened a new era of splendid conquests in the surgical field, thus making possible certain operations which it would have been short of a folly to carry out without anesthesia.

From most ancient times attempts were made to free from pain patients undergoing surgical operations. The first instance of anesthesia, says Simpson, was found as practised by God himself in creating the first woman, for, according to Genesis, "The Lord God cast a deep sleep upon Adam (*Immisit Dominus soporem in Adam*), when he took one of his ribs to make Eve. But we may dispense with a deep research of the earliest origins of anesthesia, and state it is certain that the ancients tried several measures with the view of obtaining insensibility, but nevertheless the problem of surgical anesthesia can not be said to have been announced to the world till the seventeenth century, when Denis Papin declared that certain means existed, "either known or to be discovered,'' by which sensibility in patients could be suspended, thus sparing them all pain in surgical operations. But Papin's happy idea remained unfulfilled for more than a century. To look at the early dawn of anesthesia, we have to go back to the year 1799, in which Davy held his first investigations on nitrous oxide, at the Pneumatic Institute founded in Clifton by Beddoes.

These experiments, however, while they gave birth to a new light, were not sufficient to enlist full confidence among investigators and practitioners. It was required that Horatius Wells should again point out the properties of nitrous oxide, and Jackson and Morton those of ether, ere the scientific problem of anesthesia could be put really on the road to a definite solution.

Since the first experiments of Jackson and Morton, ether began to be used as an anesthetic. Several years afterward Flourens made it known that chloroform—discovered already since 1821, by Soubeiran, but left till that time without any practical application—exercises an action analogous to that of ether, even with more strength and rapidity.

A long and bitter contention followed among experimenters and practitioners. While some sustained that ether should be preferred, others would extol the advantages which chloroform possessed over ether as a general anesthetic.

We may put aside this question, as it can be said that our days are definitively settled in favor of chloroform; and we can simply point out that the discovery of the properties of ether, with that of chloroform, goes to solve, one might say, the problem of anesthesia.

Thus the *divinum opus* of Hippocrates was realized. But, one after the other, some grave drawbacks attended the practice of anesthesia. A few of them, however, were soon remedied, as they resulted from those faulty technicalities which were in use in former times in producing anesthesia; other faults could not be mended, as they belonged to the drug itself. On these accounts investigators and practitioners set out in search of means to overcome such inconveniences; thus have arisen in succession the several methods of *mixed anesthesia*.

Indeed, as it is with the greater part of scientific discoveries, even that of mixed anesthesia is due to a fortuitous case.

In 1864, Nussbaum, professor of the Surgical Clinic at Monaco, was operating on a tumor in neck of a woman who had been chloroformed. The operation being a laborious one, and already much protracted, Nussbaum, as he was afraid of further prolonging the chloroform narcosis, conceived the thought of injecting hydrochlorate of morphin into the cellular subcutaneous tissue of the patient, when, to his great amazement, he saw the narcosis reappear, that narcosis which had already faded away.

Contemporaneously Claude Bernard injected into a dog, which had been subjected to chloroformization and was awakening, 5 gr. of hydrochlorate of morphin, and he, too, observed the reappearance of chloroform insensibility.

Nussbaum and Bernard, be it noticed, made these observations in the same year, at the distance of a few days, and each independently of the other. What Dastre and Dubois have stated on this matter, therefore, is not true. The former, in his book, "*Les Anesthésiques*," page 233, says: "This idea (that of mixed anesthesia) had been realized in 1873 by Nussbaum, but preconized and studied much earlier (1869) by Claude Bernard in France.

Dubois says: "In 1869 Cl. Bernard had preconized, etc. * * * and only in 1873 the process of Cl. Bernard was applied in the clinics by Nussbaum."

It is therefore well established, even according to Bernard, that the first mixed anesthesia, that is the association of morphin with chloroform, was practiced contemporaneously at the patient's bedside by Nussbaum and in the laboratory by Bernard. Thus it is well to observe that in those first experiments the injection of morphin was made after chloroformization! Then, while Nussbaum maintained this method, afterwards called "Narcosis of Nussbaum," Bernard modified and enlarged the sphere of his first researches and proposed that the injection of morphin be made before chloroformization, and this process was named "Process of Cl. Bernard."

The association of morphin with chloroform offers more than one advantage. By Nussbaum's method, as well as by Bernard's, it is certain that a notable sparing of chloroform is obtained, those dangers being thus avoided which result from a chloroform narcosis too much protracted.

The administration of morphin before chloroformization (in Bernard's method) offers other benefits of a great value; that is, before all, it suppresses, or at least it shortens the period of chloroform excitement; secondly, it prevents the laryngo-reflex syncope, which is always to be feared when only chloroform is used, and which, as it is known, is caused by irritation of the respiratory canals.

Nevertheless this method soon opened the way to strong objections, which may be reduced to the following main points:

1. Morphin facilitates the respiratory syncope, an accident (François Frank-Verneuil) which really can take place even with the chloroform alone, but, it has been observed; that more frequently it happens in the combined method.

This objection, however, is of very little importance, and, indeed, is not such as to be able to condemn the combined use of morphin and chloroform. In fact, the respiratory syncope does not present a serious danger to life, in as much as it can be overcome with great facility by simple pressure on the chest.

2. Morphin induces stupor, increases the effects of traumatic shock and determines a decided lowering of temperature.

3. Morphin (an alkaloid depressant) adds to the toxicity of chloroform, which is a toxic itself.

The strength of these two objections can not be denied, and are such as to perplex us in using the methods of both Bernard and Nussbaum; hence we see how logically further attempts followed from time to time to find a drug that could be associated without interfering with the chloroform.

First—Alcohol was used with chloroform.

Spencer Wells in 1867 proposed, to obtain anesthesia, to use a mixture of seventy parts of chloroform and thirty parts of methyl-alcohol. But the proposition of Wells did not meet with any favor inasmuch as in that way chloroform was still the agent without having its action corrected by alcohol. More valuable are the methods of Forné, Trélat and Perrier.

Forné to obtain anesthesia substituted the hydrate of chloral for morphin in order to diminish the dose of chloroform necessary, and to spare the patient the period of chloroform excitement.

Now if we reflect that the principal danger of chloroform narcosis lies in the stopping of the heart beats; if we think that chloral exerts a depressing action on the heart we have to conclude that the dangers of chloroformization are being much increased by the association of chloral while the advantages obtained by this drug are very slight.

As to the methods of Trelát and Perrier, that is the association of chloral with morphin and of both with chloroform, I will not speak, as I have already noted the drawbacks attending the use of Nussbaum's, Bernard's and Forné's methods.

Likewise, I may leave aside the minute description of all methods that at different times have been proposed, such as follows: association of nitrous oxide with ether (process of Clover); association of alcohol with chloroform and ether (process of Stefani and Vacchetta); association of cocain with chloroform (process of Obalinsky); of acetic ether with chloroform (process of Von Mering) and others already superseded.

I will, then, simply touch upon the principal processes, commencing with those of Dastre and Morat.[*] These experimenters proposed to associate with the morphin-chloroform narcosis the use of atropin. By this method they hoped to obtain chiefly three results, as follows:

1. To avoid nausea and vomiting which rather frequently appear after plain injections of morphin.

2. To avoid salivation, which often gives so much trouble during chloroformization.

3. Finally, and this is the principal advantage, to paralyze the moderator branches of the vagus, thus avoiding one of the greatest dangers in chloroformization, that is, the reflex stopping of the heart.

It is true that the mechanism of death in chloroform narcosis lies essentially in the transmission to the heart of an inhibitory reflex, as Dastre and Morat assert, the association of atropin with morphin in chloroformization would give the desired result. But the opinion of the above named authors can not be admitted as demonstrated; and Richet, Langlois, and Maurange express their grave doubts about it. According to Richet the cardiac syncope is determined by the direct action of chloroform on the heart. Langlois and Maurange give out the following objections: It is known, they say, how easily dogs succumb in chloroformization. Now on these animals, by means of *pneumogastric excitation*, whatever be the intensity of the current, it is but seldom that the complete action of the heart can be stopped. Even prolonging the excitement, the heart beats again several seconds after the application of the electrodes.

Moreover, they point out, also, the accidents observed after electric currents of high tension have been used, and prove the facts observed by Dr. Arsonval, of individuals, who, having received prolonged (2 minutes) shocks of alternating currents of 4500 volts, have revived by artificial respiration, 40 minutes after the establishment of the short circuit, and we conclude with Richet, "that there is no reason to attribute to chloroform the property of acting more powerfully than the strongest currents inducted and applied directly on the vagus or on any sensitive nerve." *

In spite of these objections, the action of stoppage can not be denied, which is brought about by the intermediation of the vagi, especially in case of transmission of phenomena of inhibition, that have their original centre in the bulbar nuclei. However, it is to be admitted, with Langlois and Maurange, that the importance attributed to this unique mechanism of the mortal accidents that are being brought about in the course of chloroformization has been too much exaggerated.

The physiologic arguments given above, and the clinic observations of many surgeons who are against the use of atropmorphin combined in chloroformization, induced Langlois and Maurange to search after some other process of mixed anesthesia.

Holding as a basis their own experiments, the above named authors proposed the substitution of spartein for atropin, maintaining that the following advantages can be looked for:

1st. Spartein slightly diminishes the excitability of the vagi.

2d. Spartein effectually banishes the *atony* of the heart, determined either by chloroform or by the action of the vagi.

3d. While it sustains the energy of the heart, spartein favors the elimination of morphin and of chloroform, and impedes the lowering of temperature.

In their earlier researches, Langlois and Maurange used sulphate of spartein, chemically pure; afterwards they used hydrochlorate of oxispartein, prepared by Ahrens; and their special aim was this: to compare the resistance of normal animals, under chloroform or atropinized, with that of animals that were given spartein or oxispartein, associated with morphin.

As to what pertains to the technic of the process, Langlois and Maurange advise making the injection of spartein and morphin in advance, then to submit the individual to the inhalation of chloroform. Thus a rapid narcosis would be obtained, which could easily be maintained with little chloroform, and during which pulsations would go on, always regular and full.

**Archives de Pharmaco-dynamie*, page 212.

But if we turn our attention for a moment to all that has been stated about spartein by pharmacologists and clinicians, we are permitted to doubt the advantages that would be realized by substituting spartein for atropin. In fact, not a few observers maintain, first of all, that the excitability of vagi under the influence of spartein, instead of being diminished, as Langlois and Maurange assert, is rather augmented (Rummo, Laborde, Legris, Ferranini); therefore, owing to these observations, the first advantage advocated by Langlois and Maurange in favor of spartein *would fall to the ground.*

Moreover, if we add the mutability in the action of spartein on the heart, and the fact that this alkaloid is often tolerated with difficulty, none could accuse the opinion as exaggerated that the method of Langlois and Maurange should at least be endowed with ample confirmatory proofs, both by experiments in the laboratory or by clinic observations.

Even if we admit that spartein possesses all those qualities that Langlois and Maurange attribute to it, the method of mixed anesthesia proposed by them would always leave an opening for criticism, as the use of morphin is always in it, against which we have seen so many objections raised.

Therefore, the problem of mixed anesthesia appears to me be far from being solved; for this reason I myself have sought to give to it my modest contribution.

Without caring much for the danger of inhibitory action on the heart, which, as it is known, can easily be avoided by proceeding with due precautions in using chloroform anesthesia, and by applying various other means, which it would be useless here to enumerate, I have deemed it wiser to take into closer consideration those dangers that are greater and which it is more difficult to avoid in cases of chloroformization, whenever it must be much protracted; which dangers consist chiefly in the great depression that chloroform produces on the cardiovascular apparatus. Two ways to my purpose occurs to me, one, of attempting to avoid, or, at least, to counterbalance the deleterious action of chloroform on the heart and on the circulation of the blood; the other, of attempting to combine with chloroform a certain drug that would make easy and prolong the chloroform anesthesia without exerting any obnoxious influence on the cardiovascular functions.

To obtain my first point, evidently I should have recourse to one of those drugs which can give activity to the functions of the heart and maintain the pressure of the blood.

From among such drugs I took as typical those of the pharmacologic group of digitalis; I have not taken into consideration caffein, as the use of this alkaloid had been already attempted without success by other investigators.

Before proceeding further, I beg leave to refer my experiments made by using helleborin:

TABLE I.

A medium sized dog. Preparation of the right carotid, which is connected with the kymograph.

Hours.	Pressure in m. m. of Hg.	*Observations.*
9.38	168	Animal in normal condition.
10.05	169	" " " "
10.16	169	The process of the chloroformization begins and gradually is carried on.
10.20	66	Abolition of corneal reflexes, which keeps on for two minutes.
10.40	144	Animal completely awakened.
10.52	144	Two cgr. of helleborin are given subcutaneously.
11.00	164	Chloroformization commences.
11.15	98	Complete abolition of corneal reflexes, which lasts two minutes.
11.35	158	Animal completely awakened.

II.

A small sized dog. Preparation of the right carotid which is connected with the kymograph.

Hours and minutes.	Pressure in m. m. of Hg.	*Observations.*
11.	146	Animal in normal condition.
11.10	143	Animal in normal condition.
11.20	148	Chloroformization commences and proceeds by degrees.
11.24	60	Abolition of corneal reflexes which lasts two minutes.
11.45	128	Animal complely awakened.
12.	128	1 cgr. of helleborin is administered hypodermically.
12.20	142	The animal is chloroformed.
12.30	92	Abolition of corneal reflexes for two minutes.
12.50	137	Animal completely awakened.

If we glance at the figures in the above experiments, which are corroborated by others that I omit for brevity's sake, we perceive at once this fact, that by giving helleborin before proceeding to chloroform inhalation, the lowering of the blood pressure during chloroformization is much diminished, and the heart accomplishes its work with due energy and regularity.

I have not, however, been satisfied with only these happy results, as the period of chloroform excitement has not been modified in any way. The dose of chloroform necessary to produce anesthesia had remained the same; the anesthesia sleep was not being prolonged, therefore many of the drawbacks attending mixed anesthesia were still there.

I now searched for a drug that could shorten the induction of chloroform-anesthesia, and to prolong it without hurting the cardiovascular apparatus nor any other of the principal functions of the human organism.

The most synergic substances among anesthetics are those of the group of hypnotics. To such drugs, therefore, I naturally turned my attention above all others, and already advised as to the physiologic actions of the general hypnotics, I was entitled to put aside some of them,'and to concentrate my studies on others.

Thus, for the harmful actions produced, principally upon the cardiovascular apparatus, the association of chloral hydrate and chloroform was certainly not to be tested, as this had already been tried without success by Forné, as we have seen above, and for the same reasons other agents were passed as well.

Now paraldehyde appeared to me as the *a priori* drug most fit for my purpose, and my experiments have fully confirmed the theoretic provisions, as I will show further on.

First of all, I beg leave to briefly review some of the most important notions about paraldehyde; just as they have been experimentally demonstrated in the laboratory and afterward fully confirmed by clinic observations.

Paraldehyde is a plain polimeric modification of aldehyde, as the molecule of paraldehyde is derived from the condensation of three molecules of aldehyde. The illustrious V. Cervello, whom I had the great honor to have as my professor, and in whose laboratory I have made these experiments, first of all proposed paraldehyde in therapy, after having studied it minutely in the laboratory, and the results he obtained were of such great importance that many pharmacologists and therapists were led to study that drug.

Thus in a few years paraldehyde literature has been enriched by many works, which completely corroborated what Professor Cervello had already announced. Paraldehyde, as a hypnotic, is by far preferable to hydrate of chloral; and if in medical practice it has not supplanted chloral, this is to be attributed only to the fact that paraldehyde on account of its acute odor and disagreeable taste is very repugnant to many patients. There are, however, cases in which paraldehyde is absolutely preconized and the use of chloral is actually contraindicated; that is, whenever sleep must be induced in individuals who suffer from heart conditions. In fact under such conditions, chloral, on account of its well known depressing action on the cardiovascular system, would make the patient worse, exposing him to serious danger; paraldehyde, on the contrary, sparing completely the heart and the circulatory system, even giving some relief to the cardiac function, proves to be of very great practical usefulness.

It is not my intention to relate those actions of paraldehyde, which are already so well known, nor to show all its advantages as a hypnotic; I will confine myself to those points only that bear especially upon my purpose. The principal advantage of paraldehyde over other hypnotics is that of not hurting the cardiovascular system. The heart, under the influence of paraldehyde, not only does not suffer any harmful modifications, but even, with small and moderate doses, is being facilitated in its functions; and, even in doses moderately large, variations take place which are inconsiderable so far as number and strength of cardiac pulsations are concerned. Very often in the laboratory of Prof. Cervello we succeeded in stimulating to activity frog hearts, subjected to artificial circulation in Williams' apparatus, which had shown little activity and notable aritony, by having added only one or a few drops of paraldehyde to the external baths in which the heart was immerged.

The blood pressure, likewise, does not suffer any lowering with paraldehyde in doses as recorded above; even in small and moderate doses one can often notice a slight increase in the pressure. The respiration, also, does not suffer any alteration, but it continues regular and even. With paraldehyde the sleep is not heralded by excitement, nor is it followed by those disagreeable phenomena that so often take place when use is made of the most of the other hypnotics. With paraldehyde there is no salivation or vomiting, which are apt to appear when hydrate of chloral is used.

Lastly, as to the action of paraldehyde upon the reflex sensation, it is known how easily this substance diminishes or even annihilates cutaneous sensibility without the reflexes being made affected. Only with the largest, nearly always deadly, doses do we see the reflexes disappear.

Then, by associating paraldehyde and chloroform, it was reasonable for us to expect, firstly, the suppression of the period of excitement, of vomiting, of salivation, etc.; the rapid production of anesthesia with small quantities of chloroform and the prolongation of the same; secondly, no harmful influence on the heart, even some advantage to the cardiovascular function.

My experiments along these lines have gone beyond my expectations and to relate these I now wish to refer briefly to the results of some of my experiments:

TABLE III.

1.

Dog—Weight, kgr. 10.100. Preparation of the right carotid which is connected with the kymograph.

Hours and minutes.	Pressure in m.m. of Hg.	*Observations.*
10.00	153	Animal in normal condition.
10.10	152	Animal in normal condition.
10.15	152	8 gr. of paraldehyde in water at 4 per cent. are given by mouth.
10.50	156	Dog sleeps soundly.
10.55	156	Chloroformization begun with only a few inhalations. No phenomenon of excitement is being observed.
10.57	120	Complete abolition of corneal reflexes which lasts about thirteen minutes.
11.48	....	Chloroform action completely ceases. The animal continues to sleep soundly.

2.

Dog—Weight, kgr. 4.70. Preparation of the right carotid, which is connected with the kymograph.

Hours and minutes.	Pressure in m. m. of Hg.	*Observations.*
9.57	174	Animal in normal condition.
10.07	172	" " "
10.15	172	3.25 gr. of paraldehyde in water at 4 per cent. are given by mouth.
10.51	164	Animal sleeps soundly.
10.52	164	Chloroformization commences by only a few inhalations. No phenomenon of excitement is observed.
10.54	128	The corneal reflexes disappear for about 12 minutes.
11.50	....	Chloroform action completely ceases. The animal keeps on sleeping soundly.

3.

Dog—Weight, kgr. 8.200. Preparation of the right carotid, which is connected with the kymograph.

Hours and minutes.	Pressure in m. m. of Hg.	*Observations.*
9.00	164	Animal in normal condition.
9.15	161	" " "
9.20	161	6.60 grs. of paraldehyde in water at 4 per cent. are given by mouth.
10.00	158	Animal sleeps soundly.
10.05	158	Chloroformization commences by only a few inhalations. No phenomenon of excitement is observed.
10.07	126	The corneal reflexes disappear for 14 minutes.
10.55	....	Chloroform action completely ceases. The dog continues to sleep soundly.

4.

Dog—Weight, kgr. 5. Preparation of the right carotid, which is connected with the kymograph.

Hours and minutes.	Pressure in m. m. of Hg.	*Observations.*
10.15	170	Animal in normal condition.
10.30	168	" " "
10.40	168	4 grs. of paraldehyde in water at 4 per cent. are given by mouth.
11.22	169	Dog sleeps soundly.
11.25	169	Chloroformization commences by only a few inhalations. No phenomenon of excitement is being observed.
11.27	133	Complete abolition of corneal reflexes which lasts about 12 minutes.
12.20	....	Chloroform action completely ceases. The animal continues to sleep soundly.

5.

Dog—Weight, kgr. 5.500. Preparation of the right carotid, which is connected with kymograph.

Hours and minutes.	Pressure in m. m. of Hg.	*Observations.*
10.00	166	Animal in normal condition.
10.14	165	" " "
10.20	165	4.40 grs. of paraldehyde in water at 4 per cent. are given by mouth.
11.00	166	Dog sleeps soundly.
11.05	166	Chloroformization commences by only a few inhalations. No phenomenon of excitement is being observed.
11.08	129	Complete abolition of corneal reflexes which lasts about 13 minutes.
12.00	....	Chloroform action completely ceases. The animal continues to sleep soundly.

6.

Dog—Weight, kgr. 7.250. Preparation of the right carotid, which is connected with the kymograph.

Hours and minutes.	Pressure in m.m. of Hg.	*Observations.*
9.30	162	Animal in normal condition.
9.40	160	Animal in normal condition.
9.50	160	5.80 gr. of paraldehyde in water, at 4 per cent. are given by mouth.
10.45	159	Dog sleeps soundly.
10.50	159	Chloroformization commences by only a few inhalations. No phenomenon of excitement is being observed.
10.52	123	Complete abolition of corneal reflexes, which lasts about 12 minutes.
11.42	......	Chloroform action completely ceases. The animal continues to sleep soundly.

From the above experiments, therefore, all the results we were looking for would seem to have been obtained; moreover, the function of the heart has been maintained perfectly regular, and that great lowering of the blood pressure, as ordinarily observed in chloroformization, did not in any instance take place.

My experiments yet require a large amount of proof, and I propose to proceed still further in this line, and also to study some peculiarities to which I have not yet been able to give my attention. I desire also to try to prove mixed anesthesia with paraldehyde and chloroform in the human subject.

I believe, however, that I am thus far encouraged in entertaining best hopes for the usefulness of the association of paraldehyde and chloroform; much more so if we reflect that, with so many advantages which theory authorizes me to admit, and which have been confirmed by experiments, no danger has arisen which should perplex us in the application of this method.

In conclusion, the association of paraldehyde with chloroform, owing to its effects, appears to be by far superior to all other methods of mixed anesthesia proposed by experimenters up to this time. Administering paraldehyde before the inhalation of chloroform, first of all, we remove from the patients who are rebellious or fretful that consciousness of being forced to undergo the chloroform narcosis, and this, in certain instances, will prove a great practical advantage. The period of chloroform excitement, which often is much protracted and reaches great intensity, is completely suppressed. That profuse secretion of saliva, which is so disgusting to the patient and to the operator, and which sometimes becomes even dangerous, is done away with; vomiting is not produced, at least judging from the observations I have been able to make thus far.

By previously administering paraldehyde the chloroform anesthesia is obtained in a very short time and with a very small dose of chloroform; the sleep proceeds soundly, respiration continues calmly, the heart works on with perfect regularity, and the blood pressure, even in the deepest narcosis, is strong enough.

Another fact not to be passed over is, that with paraldehyde the sleep is much prolonged, even after the cessation of anesthesia, the patient awakes some little time after the operation is over, already revived and without suffering the effects of trauma.

Before ending this memoir, I wish to insist upon one last point, that is with the hope that by having recourse to the association of paraldehyde with chloroform, it should be made possible to practice anesthesia without any danger even to those patients who are affected with heart diseases and for whom the plain chloroform narcosis is absolutely contraindicated.

We know, indeed, that paraldehyde does not provoke trouble in such patients, and the quantity of chloroform necessary to produce anesthesia in such cases becomes so small that all danger for the cardiovascular function is to be considered as avoided.

HISTORY OF SMALL-POX.*

By Dr. L. G. LeBeuf, New Orleans.

Variola, from the Latin word *varus*, or the diminutive of the word *varus*, which means pimple, was used in ancient times to designate any skin affection with the accompaniment of pimples or papules or pustules. At a latter date it was used only to designate small-pox; that latter word came from the word "pock," meaning a bag or sack, from the appearance of its principal symptom. It was called small-pox in contradistinction to *la grande vérole*, as the eruption of syphilis was denominated. In France it was known as *la petite vérole* and applied only to small-pox, though for a long period of history the two were confounded together and the diagnosis of small-pox was invariably mixed with that of measles, syphilis, bubonic plague and some other exanthematous diseases. The first physician who limited the application of the name small-pox to variola was Constantinus Africanus. The exact origin of this most loathsome disease is shrouded in mystery. It seemed to have been known in the most ancient times, but it was so much confounded with some of the dreadful plagues that visited the remote periods of history that we can not accurately tell the date of its first appearance. Small-pox is certainly not indigenous to Europe, and was not known in America prior to the conquest of Mexico by Cortez. It is often said that Hippocrates and Celsus knew of it, but that has not been definitely proven; even in the descriptions given by Galen we can not recognize all the features of small-pox.

We are certain at this day that we owe this disease to China and Hindustan, where the over-crowded condition of the population naturally increased the possibility of all contagious and infectious diseases. Moore dates the earliest knowledge of it to 1120 B. C., but later researches do not support this opinion.

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* Read before the Orleans Parish Medical Society, January 27, 1900.

In India, before the time of Christ, a goddess was worshiped whose friendly intervention was supposed to preserve the faithful from the dreaded disease. Historically, the first report of small-pox was handed down to us in 544 by Procopius, who gave a description of the disease in his *de Bello Persico*; in this he described an epidemic or scourge which took place at Pelusium, and which invaded Egypt, Syria and the whole of Asia. But Gregory considered that even this is more apt to have been bubonic plague than variola, though in Book II, Chapter 22, he describes symptoms that could have well been small-pox. The first certain knowledge we have of the disease we owe to a description of a fearful scourge which took place in 581 A. D., given by Gregory of Tours. It raged all through Southern Europe and was distinctly differentiated by the chronicler from an epidemic of bubonic plague, which broke out the following year, 582, at Narbonne. This scourge was known as "*lues cum vesicis*, *pustula pustulæ*, or *morb. dysentericus cum pustulis*," in contradistinction to *morb. inguinarius*, or bubonic plague. In a narrative of one of the expeditions of the Abyssinians against Mecca, Gregory also refers to a breaking out among the invading army, but he clothes this description with all manner of of superstition, mystery and tradition.

Still it is to the Arabians, and especially to Rhazes, that we owe our first exact knowledge of any technic status of the disease. He was a noted scientist, born in 850. After traveling through the far East and studying in Spain, he practiced medicine in Bagdad. He wrote many works on medicine and philosophy, and also a Cyclopedia on Medical Science, and finally a Treatise on Small-Pox and Measles, which was translated at Poitiers in 1556 by S. Collin. He had a theory on the pathology of the disease, and labored under the impression that it was due to some fermentative state of the blood. Whatever may have been his errors in the etiology and pathology of the disease, he gave us such good suggestions for its treatment that we of the present time could afford to follow them. He rubbed his patients with oils and salves to prevent pitting. This method was evidently abused, for we are told that a Bishop Felix of Nantes used a blister salve on his leg and died of the gangrene resulting from it. Constantinus Africanus, born in Carthage, at the beginning of the twelfth century, began by his teaching and works to educate Italy in medical matters, and raised science in that country to the degree attained by the East and Ancient Greece. His teachings were concise, and in his description of small-pox he followed the lines taught by his Arabian predecessors. Before the time of Constantinus we know very little of the history of small-pox in Europe, though it was known to have devastated whole regions at a time. Certainly the frequent Crusades must have brought the contagion many times, and then again when the Moors invaded Spain they brought the scourges of the great East with them. It was only after such momentous migrations or invasions that disease could spread in those days. Because of the scant communication between countries, the nations and their people never met. A narrow sea or a low range of mountains intercepted communication. It will readily be understood why the diseases of one country were scarcely known by another.

Variola entered England in 1241, in Sweden in the middle of the fifteenth century, and in Germany at the end of that century. It was introduced in America through Mexico in 1527, and rapidly overran the whole of the Western Hemisphere. It is certain that it was not known by the North American Indians; the early explorers never saw the tell-tale pock mark on the red man's face. Would not this go to disprove the alleged connection said to exist between the Aztec civilization with that of India, or place this consanguinity very far away in the earliest times? In America the disease had gained a foothold, and it continues its ravages periodically to our day. It was stimulated in its potency of contagion by the large importation of negro slaves from Africa during the time of slavery.

After the period of the Crusades, small-pox became widely spread all over Europe, and rapidly became the greatest scourge that humanity had to contend with. It decimated large regions of country, depopulated and impoverished others. All methods and all theories were tried to check this dreaded invasion, but they came to naught, and the ravager kept on its course of death and destruction. It was more feared than the plague. The "Wandering Jew" of Eugene Sue, though it gives in a masterful way the fear and panic it brought to all minds, still conveys but a faint idea of its terrors. The salves and sweating processes introduced by the Eastern physicians, Arabian and others, were abandoned about the beginning of the seventeenth century for the sensible antiphlogistic treatment suggested by the celebated Sydenham. Still in spite of this the ravages kept on, and mankind was the prey to its merciless inroads, and scarcely a decade elapsed that the victims were not counted by thousands, or tens of thousands. Many plans and procedures were tried but all to no avail. In the time of King Edward II, his son Prince John, was treated by being placed in bed with red curtains around it: he was covered with red blankets, he was made to suck the juice of a red pomegranate and to gargle his throat with red mulberry wine. About this time in opposition to the belief that the aged or those above 60 years of age were less subject to variola, we have the notable historic fact of the of death Louis XV of France, who contracted the disease from a child who had scarcely reached the age of puberty and who had been brought to this lascivious, shameless and corrupt being. At about the seventeenth and eighteenth centuries, 7 to 9 per cent. of all deaths were due to small-pox. From 1783 to 1797, one-twelfth of the total mortality of Berlin was of variola. During the eighteenth century there were thirty thousand deaths in France actually due to it. Von Junker states in the "*Archiv der Aerzte und Seelsorger wieder die Pockenothe*," of the year 1796—the very year that Edward Jenner finished his final experiment on the cow-pox—that 26,646 inhabitants of Prussia died that year with this disease out of a population of seven million inhabitants. The first step in the direction of prophylaxis was made by the process of inoculation in the seventeenth century. This method might be better called variolization, and it was practised in China and India before that time, only we have no perfect record of its first trial. It was positively performed in Constantinople in 1673 and for a long time afterwards, principally on young children after their physical condition had been prepared by a system of dieting and laxatives. It was in 1717 that Lady Wortley Montagu heard of this method while in Constantinople and inoculated her son with the small-pox virus. Four years later, when she returned to England, she also inoculated her daughter successfully. Though this met with opposition from the legitimate profession, it became widely popular, and even in this country up to 1845, I can certify that inoculation was performed by many English surgeons, as I have the illustration of it in my own family. A grand parent of my wife, an English army surgeon, retired in Montreal, inoculated all his children before they were two or three years of age. None of them ever had more than two or three slight pitting marks and were only very slightly ill. He prepared them thoroughly for the process and never lost any patients by it. Still this was only a crude method and laid the operator liable to fearful risks, because even if there was only a minimum danger to the patient, the person inoculated could easily infect those around him. Laws were promulgated against the performance of inoculation. It was only at the end of the eighteenth century, in 1796, that Edward Jenner came with his great discovery to allay the fear and horror of this terrible scourge. His discovery certainly opened a new era in the line of preventive medicine. It was the "open sesame" of serum therapy. To-day the mortality from small-pox is, I believe, only one in 2377 inhabitants, when before it was in many countries one to every ten deaths that occurred. Statisticians also claim that the average of life has been increased two or three years more than it was formerly. And finally, in the mere fact of blindness, the diminution since the practice of vaccination has been fully one-fourth.

Let us make a rapid calculation of the financial benefit to the world of such a saving of human life. When we think of the loss in time and money, of sickness, suffering and death, we can appreciate the great benefit of this gigantic discovery.

Vaccination is compulsory in Bavaria, Sweden, Scotland, England and Germany. In France and America it became compulsory only in the schools and some of the departments of the government. Vaccination, or the process of giving cow-pox, or vaccinia, to human beings to protect them from variola, may be well considered to have been established with the discoveries and researches of Edward Jenner in 1796. It is true that the ancients tell us that there was a method in vogue in India and ancient Persia by which men were protected from small-pox, but as this method was never properly explained, and as it was not handed to us in any way that we could use it practically, it was useless to us. Of course this method must have been a process of variolization or inoculation, as we have accurate record of its being practised in Constantinople since 1673. But it was not before the time of Edward Jenner, on the Plains of Berkley, that this learned scientist, experimenting between the years 1775 to 1798, was able, with incontestible facts to establish the preserving power of the virus of cow-pox against variola when inoculated properly in human beings. It was certainly one of the greatest discoveries of that period, and will forever mark that period as the opening age of enlightenment in the field of progressive medicine.

Clinical Lecture.

THE TREATMENT OF ATROPHIC RHINITIS.

By D. BRADEN KYLE, M. D.

[Specially reported for the JOURNAL from the Philadelphia Clinics.]

Atrophic rhinitis is not of itself an inflammation, though spoken of as such, but is the result of pre-existing conditions. There are three varieties according to the causes which have given rise to the condition. First, that variety which follows an inflammatory process in the nasal mucous membrane. The fibrous tissues formed contract, thus also lessening the blood-supply to the part which in itself tends to cause atrophy, and the pressure also lessens the functions of the glandular elements. Second, a variety which is really a pressure-atrophy. This is caused by some interference with the systematic circulation and the blood being dammed back, causes, by pressure, atrophy of the connective tissue and the glandular elements. It is a cyanostic congestion and has its counterpart in red atrophy of the liver. Third, there is a variety which is a simple atrophy or a trophic process.

Regarding the treatment of the first variety or that secondary to inflammation, what healthy mucous membrane is left should be kept in good condition. In the early stage, if seen, the cause of the inflammation should be removed if possible. A good general rule is to stimulate all secretions of the body and thus aid in getting rid of the exciting or predisposing cause. Locally warm water is as good an application as can be used at first. This should not be too warm at first, but of such temperature that the patient can bear it comfortably. As he gets accustomed to its use it should be made warmer and finally as hot as it can be borne.

After this some of the essential oils should be applied. An ordinary medicine dropper is as good an instrument as can be used, two or three drops being introduced at a time and the patient instructed not to inspire deeply after it is applied. I do not like atomizers very well. The oil of sandalwood is one of the best that can be used; from one to four drops in liquid albolene being applied. If desired, one grain of camphor may be added to this.

Where there are here and there points of contraction, the physician should make the applications himself, and apply only to the affected places. Menthol should not be used in this condition. Later in the course of the treatment, when the atrophy is more pronounced and a more stimulating application is desired, the oil of cinnamon, one drop to the ounce, may be used. Or, if a still greater degree of stimulation is thought necessary use the oil of mustard in the same strength.

The latter is a very useful diagnostic agent. If a patient comes with an advanced stage of atrophic rhinitis and the real condition is not known, use the oil of mustard, a drop to the ounce. If this is not felt, increase the strength to two drops to the ounce. If this still fails in producing sensation, increase to three or even four drops. If the latter strength is used without response, the case may be regarded as one in which the atrophy is complete and cure is impossible.

Internally, one one-hundredth of phosphorus and one-eighth to one-sixth of iodin in bromin may be given in sherry wine three or four times a day. The iodin in bromin is difficult of preparation and takes considerable time, but the results from its use are good. Arsenic preparations also act nicely in many cases, the double sulphide in one-twenty-fourth to one-twelfth grain doses after meals generally producing the most favorable effect. For stimulating the secretions in general, the phosphate of sodium is one of the best remedies that can be employed. The granular effervescing kind is the best to recommend. As the condition advances, something more stimulating may be indicated, when the syrup of the lactophosphate of lime may be substituted.

In an advanced case of atrophic rhinitis following an inflammatory process, the main indication is to make the patient comfortable. He can not be cured in the sense of restoring the former condition of the mucous membrane, but from his standpoint he can be cured, perhaps. What he wants is to be relieved of the symptoms present. Something should be done in these cases to relieve the patient of the odor or the ozena, which is horrible in many instances. Fortunately, or unfortunately, for the patient, he can not detect this odor, or at least to any great extent; but he is conscious of its presence and thinks people avoid him on account of it, and thus is led to withdraw himself from society, and perhaps becomes melancholic. Suicide has even been induced by this condition when unrelieved by treatment.

Ozena is variously written of as a disease or a symptom, but its proper place is as a symptom. The word, from its derivation, means a stench, and this condition is met with in other affections than rhinitis, syphilis, for instance. In treating this symptom the nostrils should be cleansed as thoroughly as possible with water as hot as it can be borne. Then an alkaline douche, consisting of sodium biborate, sodium bicarbonate, sodium chlorate and potassium bicarbonate, fifteen grains of each, to two ounces of warm water, should follow. If this is persisted in the nostrils can be pretty thoroughly cleansed, and the formation of slugs, which give rise to the disagreeable odor, prevented if a further step be taken. This consists in the application of common lamp oil to the parts. The oil of sassafras may be used to disguise the odor if it is offensive to the patient, or myrrh or other means may be employed. This is the better way to do, and not tell the patient what he is using, as many will think this such a common remedy that it will be hard to get them to persist in its use. Ichthyol may be used instead of the lamp oil, but it does not give such good results.

If this treatment is well carried out, the patient will find that a longer time will intervene between treatments, so that two a week, or one, or perhaps one in two weeks only, will be required. This the patient soon learns to determine for himself, and when the slugs begin to form he resorts to means to prevent them.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

ALUMNI ASSOCIATIONS: INCIDENTALLY A DENTAL COLLEGE.

Alumni Associations are calculated in the main to serve two purposes: to cultivate good fellowship and cement friendship among those who have imbibed knowledge from the same fount, in other words, to perpetuate a sort of brotherhood among former college mates; and to do all in their power to assist, improve and advance the parent institution.

Usually, we believe, the first purpose is achieved. At any rate, here in Louisiana it seems to be the case with such associations as are under medical influences, notably the Charity Hospital Alumni and the Alumni Association of Tulane. Both of these have made some effort in the direction of the second object and both with some measure of success, at least apparently.

We believe that both can accomplish a great deal of good if they persevere in their attempt to benefit their respective Alma Maters, and especially the students attached thereto. We think, also, that the directors or trustees of the institutions should receive all suggestions or advice in the spirit in which they are offered, not considering them out of place, nor either as derogatory to their dignity or a reflection on their wisdom. However, if the alumni expect to receive proper consideration on the part of administrators they must be careful to present their case properly, and be especially cautious not to allow personal equations to figure nor interested motives to guide them.

We are led to these remarks chiefly by the proposed action of the Tulane Alumni in recommending the Tulane Board to gather in the newly established dental college. We deem such action out of place. We believe Tulane should have a dental department and that it will have one some day; but we also believe it should be a branch of the medical department. We have only admiration for the enterprise and energy of the gentlemen who have founded the New Orleans College of Dentistry, many of them esteemed friends; but we consider that the proposed action smacks too much of interested influence, and advise the Alumni Association not to take it. Let them recommend the establishment of a dental or any other department which they think advisable and to the interest of Tulane and of education, but let them leave personal questions to the discretion and judgment of the Board, which is fully competent.

VACCINATION.

For three years, at least, there has been a widespread epidemic of small-pox over the whole of the United States and in Great Britain as well.

Once more the efficiency of proper vaccination has been demonstrated at almost every point where it has been employed. The popular prejudice in Great Britain amended the act of compulsory vaccination, and subsequently regretted the repeal when the exigency came.

In the United States vaccination has been general, but apparently not general enough, as in some districts—country districts especially—there appear to be fresh foci of infection.

The methods of improved vaccination employed to-day by the intelligent doctor, and the municipal and sanitary officials, are doing away with the accidents of vaccination; accidents which are due almost invariably to septic infection. The hue and cry of the fanatics who have attacked vaccination through lack of something more profitable in the way of occupation, has not been so blatant since small-pox has lately prevailed.

In Louisiana the small-pox has been well fought, and the health officials are to be congratulated for their prompt and efficient work both in urban and country districts.

THE STATE MEDICAL SOCIETY.

There are many reasons why there should be a large meeting of our State Society this year; above all, thatof organization. The absence of a large number of local medical bodies precludes the organization of the medical profession in Louisiana, except through the State Association.

The meeting will take place in New Orleans, as we have already noted, on April 19, 20 and 21, and every facility has been offered those who wish to come.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans

Penetrating Stab-wound of the Bladder Through the Sciatic Notch Severing the Gluteal Artery—Ligation, Laparotomy, Recovery.—Mr. Fontan, of Toulon, relates in the *Revue de Chirurgie* (December 10, 1899) the case of a man who, after being stabbed in the left thigh, had copious hemorrhages, violent pains in the abdomen with considerable distention. He was very weak, had frequent nausea and all the signs of hemorrhage and abdominal shock. It was very evident that an important blood vessel had been wounded, and as furthermore on introducing a catheter into the bladder, blood was drawn, a wound of the bladder was made certain. Not knowing whether the wound was intra or extra peritoneal, Mr. Fontan performed an exploratory laparotomy. Finding that the infiltration of the blood was sub-peritoneal, he closed the peritoneum and explored in the region of the bladder. On introducing deeply a grooved director in the gluteal wound, it entered the pelvis through the lower portion of the great sciatic notch, lodging on the posterior surface of the bladder. A solution of boracic acid, thrown into the bladder, returned through the pelvis. The wound of the bladder was thus made certain, but it was impossible to locate it. Mr. Fontan then inserted a strip of iodoform gauze near the posterior surface of the bladder, the other end of the tent protruding at the lower part of the abdominal wound, which he sutured. By cutting a large, deep flap he exposed the several ends of the gluteal artery. The catheter was left in the bladder. Favorable results followed.

RESECTION FOR AN OLD DISLOCATION OF THE HUMERUS, WITH AFTER RESULTS.—Mr. Dubujadoux presents the case of a man, aged 40 years, who for the past five months had been troubled by an intra-coracoid dislocation of the head of the humerus, rendering the arm impotent. Reduction with chloroform and with powerful traction was fruitless. Arthrotomy reveals the head so adherent and fixed that Mr. Dubujadoux decides to resect. On the eighth day slight movements were given the arm, and at the end of two months all motion, with the exception of the external rotation, was amply performed.—*Revue de Chirurgie.*

HOW THE RADIOGRAPH MAY BE MISLEADING.—At the Paris Society of Surgery, December 27, Lucas-Championnière spoke of the dangers of being misled by a radiograph of a callus after fracture, if the light was held in a wrong position when the radiograph was made. Even when manual examination shows the bone to be united in a good position a radiograph may make it look deformed. In consequence some surgeons have denied the accuracy of these shadow pictures. There is danger also that they may be used to influence the mind of a jury in a suit for malpractice. The volume, dimensions and form of the shadow vary not only with the distance of the object from the plate, but the light as well, so that two successive radiographs, unless the bone, the photographic plate, and the light are in exactly the same positions, will show two different deformities at the site of fracture. This variation in the size of objects is readily shown by taking a radiograph of a hand holding a needle and then taking a second one with the light at a greater distance. The needle in the former case may easily appear twice as long in comparison to the bones of the hand as it does in the latter. These facts should be borne in mind in forming an opinion from a radiograph as to the amount of deformity which follows a fracture.—*Medical News*, Feb. 3, 1900.

VEGETABLES AS A SOURCE OF TETANUS.—The late Mr. Henry Thompson (*Lancet*, January 20) records a case of tetanus following nephropexy in which no possible source of germ introduction would seem to be traceable through the wound. The The author says: "But in the case I have narrated how could any bacillus from earth or elsewhere have come in contact with the wound? A day or two before the operation the patient ate celery for luncheon. Could some bacilli have been present in the imperfectly cleansed celery and have come in contact with an abrasion in the mouth?" It is of course well known that the soil is the special habitat of the tetanus bacillus, and that vegetables taken from the soil may be a peculiar source of danger would seem therefore to follow naturally. Such vegetables as potatoes, cabbages, etc., which are boiled before use, would of course be rendered innocuous thereby; but the danger from celery, lettuce, radishes, and especially strawberries, concerning which many poople hold that to wash them spoils their flavor, if not sufficiently cleansed, is one that needs consideration.—*N. Y. Medical Journal,* February 10, 1900.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. J. C. MILLER,
New Orleans, La.

A NEW OPERATION FOR PERSISTENT INVERSION OF THE UTERUS.—Barton Cooke Hirsh contributes to the January number of the *American Journal of Obstetrics* the description of a new procedure for reducing inversion of the uterus which he has applied very successfully. He reviews the dangers of the prolonged use of the colpeurynter, of Gaillard Thomas' proposal to perform abdominal section and dilate the cervical rings from above while an assistant returns the uterus, and Küstner's method of making a long wound across the posterior vaginal vault into the peritoneal cavity, cutting through the posterior uterine wall in the middle line and reinverting the uterus. As the chief obstacle in reducing an inverted uterus is the contracted ring muscle of the cervix, Hirsh removes this obstruction by the easiest, simplest and safest plan, namely, by cutting the cervical muscle in two, which can be done in a few seconds, without opening the peritoneal cavity, without danger, and with the result of immediately removing the only obstacle to replacements. Hirsh states that the old idea of adhesions obstructing the replacement of an inverted womb has been dissipated by all modern observation.

THE FREQUENCY AND MORTALITY OF ABNORMAL PELVES.—Edward P. Davis (*American Journal of Obstetrics*, Jan., 1900), contributes the result of his examination of the records of 1224 patients who were examined by pelvimetry and palpation both external and internal. These were of all races inhabiting the United States, except Chinese and Indians. A few years ago it was commonly believed that abnormal pelves were rare in America, but when pelvimetry was regularly practiced in obstetric clinics it was at once observed that a very considerable number of patients presented themselves whose pelves were contracted or in some dimension differed from the average. The records of European clinics show a variation in percentages reported from 1.2 per cent. in Russian clinics, to 24.3 per cent. as observed by Leopold, of Dresden. Among American observers, Flint, in New York, found 1.42 per cent. of contractions; Reynolds, in Boston, 1.13 per cent.; Crossen, in St. Louis, 7 per cent.; Doppin, in Baltimore, 11.45 per cent., and Williams, in Baltimore, 13.1 per cent.

The average size of the pelvis upon which the 1224 records of Davis were based were, anterior superior spines, 24 to 26½ centimetres; crests, 28½ centimetres; trochanters, 32 centimetres; right oblique diameter, 22½ centimetres; left oblique, 21 to 22½ centimetres; internal conjugate, 11½ centimetres; external conjugate, 20½ centimetres; circumference, 85 to 90 centimetres. A variation from the average measurement of 2 centimetres in the antero posterior diameter, or of 2 centimetres in any other two diameters was considered an abnormality.

The most frequent abnormality was contraction of the pelvis. The justo minor was the most common type, being 13 per cent. of all forms of contraction, the rachitic came next, 6 per cent.; next the flat non-cachectic, 5.7 per cent., and most rare the obliquely and irregularly contracted .2 of 1 per cent. The justo major or symmetrically enlarged pubis was found in 7 per cent. of abnormalities. Thirty-two per cent. of the 1224 cases showed abnormalities, viz.: 392.

The percentage of contracted pelves was 25, corresponding closely to Leopold's statistics.

The paramount interest attaching to this subject lies in the influence which pelvic abnormality exerts upon labor and the life and health of mother and child. It is of interest to observe in what percentage all classes of cases having normal and abnormal pelvis that labor is spontaneous. In this series 84 per cent. of labors terminated spontaneously, leaving 16 per cent. that required operative interference. Comparing this result with the course of labor in abnormal pelvis, we find that in cases of pelvic abnormality 80 per cent. of labors were spontaneous and 20 per cent. required interference. It must not be understood that in a series of highly contracted pelvis 80 per cent. of labors would be spontaneous, but it is undoubtedly true that in a very considerable number of cases (most of them contracted) labor terminates without operative interference.

The article is concluded as follows:

1. Among child bearing women in the United States of the white and negro races, 25 per cent. have pelves smaller than the average and 7 per cent. have pelves larger than the average.

2. Four-fifths of patients having abnormal pelves delivered themselves spontaneously. The operations most suitable for well marked pelvic contraction and most successful for mother and child are the induction of labor, symphysiotomy, and Cesarean section when the mother is uninfected and the child is in good condition, and embryotomy when the mother is infected and in bad condition and when the child is dead or likely soon to die.

3. The general mortality rate and the septic mortality rate of all classes of labor and of labor in abnormal pelves compare favorably with the results obtained by modern medicine and surgery when obstetric practice is conducted in accordance with modern scientific knowledge of the subject.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

A Formula for the Hypodermic Injection of Acoin.—Acoin, which is one of the new local anesthetics made by synthesis, possesses the advantage that it produces anesthesia rapidly, and that this anesthesia is maintained from forty to fifty minutes. The following solution may be used for hypodermic purposes:

℞	Acoin	16 grains.
	Chloride of sodium	15 grains.
	Distilled water	3 ounces.

—*Therapeutic Gazette.*

Dormiol—(*Journal de Médecine de Paris*) is a combination of hydrate of chloral and hydrate of amolen. It is a colorless liquid, oily in consistency, and of a camphorous odor, soluble in alcohol, ether and fatty acids.

Melzer has employed the following formula for the purpose of producing sleep:

℞	Dormiol	
	Mucilage of acacia	
	Simple syrup	àà 3 drachms.
	Distilled water	4 ounces.

M. Shake vigorously before using and give the mixture in such dose that the patient gets from 7 to 15 grains of dormiol in each dose.

—*Ibid.*

Selaginella Apus, popularly known as "*Snake Moss*," is declared by Dr. Kent to be a perfect antidote for the poison of snakes and spiders. With half a drachm of the moss is macerated thoroughly 1 fl. oz. of sweet milk. The moss is then taken out of the milk and bound on the wound, while the milk itself containing small fragments of the moss is swallowed by the patient. A number of cases have been successfully treated in this way by the author. One case cited is that of a boy of eleven years, who was bitten on the instep of his right foot by a large copperhead moccasin. In an hour the foot was swollen to double its normal size, the pain being intense. The next morning, after treatment with the moss, he was at play with only a scratch to remind him of his encounter with the snake.—*Merck's Archives.*

Sypticin is reported by Prof. L. M. Bossi to be less toxic than fluid extract of hydrastis. Given to pregnant women, sypticin exerted a sedative non-ecbolic action. The author declares that it may advantageously be given in alternation with other non-ecbolic remedies in cases of threatened abortion due to metrorrhagia as well as in obstinate metrorrhagia occurring after delivery.—*Ibid.*

SPARTEIN WITH POTASSIUM IODIDE is employed by Dr. Carrieu, of Montpelier, for cardiopathies with arteriosclerosis. Where valvular lesions accompany such generalized condition digitalis is contraindicated, because it increases blood pressure; spartein stimulates the heart without increasing blood pressure. The association of potassium iodide in these cases is indicated by the arteriosclerosis in which it is especially beneficial. The author gives the following formula.

℞	Potassium iodide	8 to 15 grn
	Spartein	1 ½ grn
	Julep	3 oz
	Syrup bitter orange peel	1 fl. oz

To be taken in the course of a day.

—*Ibid.*

A GOITRE REMEDY.—Dr. Chavette, *Chicago Medical Times*, claimed to cure every case of goitre he treated by the use of the following remedy:

℞	Zinc sulphate	
	Salicylic acid	
	Iodoform	aa 2 dr
	Boracic acid	3 dr
	Oleic acid	8 oz

Mix and keep at a boiling heat for several hours, then pour off the liquid, and when cold, bottle.

Sig: Apply to the enlarged gland, with slight friction, twice daily until a slight desquamation occurs, after which apply only once daily until the enlargement is entirely reduced. In no instance did the disease return.—*The Therapist.*

TREATMENT OF PSORIASIS VULGARIS.—Unna succeeded in curing an obstinate case of psoriasis that resisted all treatment by the following salve:

℞	Acidi salicylic	
	Acidi pyrogallici	
	Ammon. sulph. icthyol	gr xlvi
	Olei oliv	ʒiiss
	Adipis lanæ	℥iv

By the aid of the salicylic acid and the ichthyol the effect of the pyrogallic acid was greatly enhanced. In this form the salve may be safely applied also to the face without producing any irritation or discoloration of the skin.—*Ibid.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King,
New Orleans.

Neurasthenia, and Certain Affections of the Nose and Throat.—The author, M. Natier, of Paris, reports two interesting observations of neurasthenia, associated with diseases of the nose and throat. In the first case the neurasthenic symptoms seem to have originated in an elongation of the uvula, the section of which led to a complete recovery; in the second the neurasthenia according to the observers was caused and maintained by an artificial ulceration of the septum, apparently of little significance as a lesion. These observations minutely described are followed by some very judicious remarks on the part of the author, as to what should be the attitude and the conduct of the specialist in such cases.

Naturally, he lays stress on the general treatment of the neurasthenia, and the necessity of modifying by suggestion and other influences the morbid ideas of the patient. As to the local treatment, it should be instituted without hesitation in all cases, where the neurasthenia is accompanied by a clear lesion, and a correlation seems to exist between the two. The class of patients which will tax to their utmost the sagacity and the discretion of the specialist is the one where the local symptoms are somewhat imaginary, at least *sine materia*, or else are accounted for by most insignificant lesions of the nose and throat. In such cases Dr. Natier deprecates the practice of entering into the views of the neurasthenic patient, and of consequently instituting an active local treatment, in the belief that more prompt relief of the troublesome local symptoms will follow.

Thus is inaugurated a system of insignificant local intervention from which the physician does not emerge with credit to his honor or satisfaction to his conscience and pride. As to the patient, the galvano-cauterization, curetting, snaring, etc., to which he is submitted amounts to, if any, but little temporary relief.

On the other hand, these unsuccessful attempts repeated by one or more physicians are very apt to bring about discouragement to the patient and lack of confidence in his attendant, who, having exhausted his therapeutic armamentarium, has only succeeded in rooting more deeply in his patient's mind the fixed idea that his whole trouble is caused by a local lesion. Thus the neurasthenia, instead of being relieved, is very much aggravated.—*La Parole*, April, 1899.

MULTIPLE TUBERCULAR TUMORS OF THE SKULL AND BOTH TYMPANIC MEMBRANES.—The case, reported by H. Freysing, of Rostock, was that of a painter, 19 years of age, with good hereditary and family history, with the exception of having had a suppuration of the ear as a result of the measles six years previously. His illness began with the appearance of a hard round painless swelling on the right leg. This was followed by stiffness of the neck and painless swellings behind the right ear and on the left side of the forehead associated with some discharge from both ears. The left drum membrane was changed into a uniformly bright red, apparently granulating mass in the lower part of which there was a perforation. Some odorless pus was seen in the meatus. The right membrane was cloudy and dull and in its posterior third there were two circumscribed grayish-yellow swellings which ran over upon the wall of the canal. Puncture proved them to be solid masses. No evidence of pulmonary or cardiac disease existed. The growths behind the ear and on the forehead were removed and proved to be tuberculous in character attacking the underlying bony structures. The small masses upon the right membrana were also removed with forceps and found to be tuberculous. These wounds healed promptly and the drum membranes cleared up slowly under the use of weak solutions of lactic and chromic acid and of ariol.

Tubercular nodules are sometimes seen in the drum membranes of children suffering from acute miliary tuberculosis and in adults with chronic tuberculosis, with rapid degeneration of the infiltrated regions, according to Schwartze, but the above described form is extremely rare.—*Archives of Otology*, October and December.

ULCERATIONS OF THE THROAT IN DIABETES.—W. Freudenthal, of New York, reports a series of five cases of ulceration of the throat, which he ascribes to diabetes. In every case sugar was found in the urine in varying quantity, and the writer makes the diagnosis by excluding syphilis, tuberculosis and the other causes of ulceration in the throat. From his observations he concludes that there are two forms of diabetic ulcerations, viz.: those of a malignant and those of a benign character. In two cases where very extensive and deep ulcerations of the pharynx, tongue and epiglottis existed treatment proved of no avail and death occurred as a result of inanition from the severe dysphagia. Two other cases recovered entirely under local treatment and one was lost to view.

Although the author has been unable to find a mention of similar cases, he is convinced of their diabetic nature, and does not find it strange that ulceration should exist in the throat when in this disease we find trophic disturbances going on in other tissues of the body.

A minute description of the appearance of the ulcers is not given, but they seem to have no special form nor location in the throat, and may resemble at times either tuberculous or syphilitic ulcers. They have a tendency to increase in extent and depth and are extremely painful. In these cases reported the lesions were found on the soft palate, the uvula, the tonsils, the tongue, mucous surface of the cheeks, the epiglottis and the arytenoid eminences.

In the local treatment the writer recommends very highly the use of orthoform for its anesthetic and antiseptic properties. He employs it combined with menthol in the following formula:

℞	Menthol	2.0 ad	10.0
	Ol. Amygdal. dulc		30.0
	Vitelli Ovi		25.0
	Orthoform		12.5
	Aquae dest. q. s. ad		100.0

Ft. emulsion, sig; shake well. Apply locally.

—*Annals of Otology.*

A Case of Total Laryngectomy for Sarcoma and the Use of an External Artificial Larynx.—In the January number of the "*Annales des Maladies de l'Oreille, du Larynx, etc.*," Dr. N. Taptas, of Constantinople, writes the observations of a most interesting case in which he performed a complete extirpation of the larynx, and afterward applied a very ingeniously constructed apparatus by means of which the patient could readily make herself understood with the whispered voice, and in other ways was relieved of some of the distressing conditions consequent upon laryngectomy. The case was that of an Armenian woman forty-six years of age, upon whom a tracheotomy and a thyrotomy had been previously performed for the removal of a sarcoma of the larynx, eight months before coming under the observation of the author. At that time, she was still wearing a tracheal canula and a recurrence of the growth had taken place, giving rise to severe pains in the throat and neck and intense dysphagia. Finding the tumor in an advanced stage of progression, total laryngectomy was decided upon as the only chance of recovery. With the view of applying an artificial vocal organ, should the patient recover, the operator performed the extirpation in the following manner: The tracheal canula being replaced by a Trendelenburg canula, an incision was made in the median line, beginning a little above the hyoid bone and terminating in the old tracheal wound below. At the lower extremity of this incision, a transverse cut was made and the sterno-thyroid and sterno-hyoid muscles exposed and separated from their attachments to the larynx. The larynx was then disengaged on each side and the trachea divided below the cricoid cartilage, leaving the organ suspended by its attachments to the lower pharyngeal mucosa behind and the hyoid ligaments anteriorly. These attachments were separated and the epiglottis divided at the level of its pedicle and left in place. To cut off all communication between the mouth and the trachea the mucous membrane detached from the posterior surface of the arytenoids was brought over and fixed by sutures to the anterior portion of the pharynx corresponding to the hyoid bone. Deep sutures were passed closing the wound above the tracheal opening, but leaving a fistula opening into the pharynx at the level of the hyoid. This latter wound was packed with gauze and the tracheal canula reinserted into the old tracheal orifice; thus two openings were left, one permitting respiration through the trachea and the other remaining as a pharyngeal fistula, no communication being left between the buccal cavity and the respiratory tract. The patient was fed by means of an urethral catheter passed through the nose, and in due time the parts healed. The artificial larynx consisted simply of this: A special canula was fitted to the pharyngeal fistula above and made to communicate with the tracheal canula below by means of a simple rubber tube, the tracheal canula being provided with a small branch tube opening upward above its usual orifice. Ordinary respiration was carried on through the tracheal canula, but when the patient wished to speak she closed the tracheal canula with the finger and the expired air was thus made to pass into the mouth through the tube communicating with the pharyngeal fistula, and an audible whisper replaced the absent voice.

The contrivance worked very satisfactorily for a time and deglutition was in no way embarrassed, but a recurrence of the malignant growth caused the death of the patient within a few months.

Miscellaneous.

TREATMENT OF ANGINA PECTORIS.—Rumpf (*Berlin. Klin. Wochenschrift*, says that on the theory that angina is dependent on calcification of the coronary arteries, decalcification of these arteries by increasing the elimination of lime is indicated. If an individual is put upon a diet poor in lime, an abundant elimination of the lime is provoked in him if he takes at the same time a solution composed of the following:

Sodium carbonate, 150 gr.
Lactic acid, a sufficient quantity to saturate it.
Add:
Lactic acid,
Syrup, of each, 150 gr.
Distilled water, 6 oz.
This amount to be taken during the day.

This also acts as a diuretic, and the quantity of lime eliminated is increased from 50 per cent. to 52 per cent. A diet which is poor in lime is also indicated. Daily diet: Meat, about 8 oz.; bread, fish, potatoes and apples, each 3 oz. This contains ten times less lime than a corresponding quantity of milk, or four times less than the diets advocated by Hoffman as substitutes for milk. The potatoes may be replaced by fresh beans, cucumbers, or peas, cheese, eggs, beets, cabbage, rice and spinach, all of which are rich in lime, are contra-indicated. These measures were employed in twelve cases of angina and atheroma, In three cases of angina the success was remarkable.

THE TREATMENT OF CROUPOUS PNEUMONIA WITH HOT-WATER BAGS.—Kolipinski thinks as soon as croupous pneumonia is diagnosed that the treatment should be as follows: A pair of hot-water bags are selected, the largest size found in the shops, preferably of the capacity of a gallon. These are filled with boiling water, well secured from leakage, and each one wrapped in a small shawl of compact texture, or in a portion of blanket cut for the purpose. They are then placed side by side on the bed so that the mouths of the bags point upward; over them is placed a third shawl folded several times, or a further piece of blanket; above them two or possibly three pillows are arranged for the patient's head. The bags thus form a sort of shallow cradle for the postscapular regions. To make the plan clear to the attendant he is told that the bags are to be placed like the knapsack on the back of a soldier and a little higher up as well. The bags are refilled every three or four hours. The exterior temperature, found by placing a common atmospheric thermometer between the coverings of the bag and the patient, varies from 95 deg. to 130 deg. F. A mean temperature of 110 deg. F. should be aimed at, as an elevation of 120 deg. F., or more, is liable to inflict severe burns on the skin, particularly so if the patient's cutaneous sensibility is for the time obtunded. These burns, which Dr. Kolipinski says he has frequently met with, due to the over zeal or excitability of the attendants, have no untoward effect in the course of the lung fever, but very probably the opposite, and a pneumonia may disappear in a day or two when this accident has happened, although the injury itself may remain for two or three weeks. The bag treatment is continued without intermission until the body temperature returns to normal and remains so for a day or two.—*Maryland Medical Journal.*

A CASE OF FRACTURE OF THE LARYNX.—A ten years old girl was injured in the anterior part of the neck by a cow. Dr. Kamnew on arriving found the girl still *compos sui*. She could talk yet and screamed, though with altered voice. On the anterior and superior surface of the neck corresponding to the middle part of the thyroid cartilage there was an oblique skin erosion one *c. m.* long and 0.2–0.5 *c. m.* large. On the face, on the neck and the upper part of the breast skin-emphysema could be detected. After one and a half hours death occurred. Shortly before the emphysema extended all over the body down to the toes. Post-mortem palpation of the larynx (during life such a procedure was impossible) gave the impression of grating and shifting of the splinters of the larynx.

P. M. examination was objected to.—*Wratsch*, 26–99.

ON PHLEGMASIA ALBA DOLENS AFTER CONFINEMENT.—Prof. Pinard, in remarking its curative treatment, says:

1. Immobilization of the limb in an apparatus resembling a gutter, but obliquely inclined.
2. Diminution of pains, if necessary, by morphin injections.
3. Injection of antistreptococcic serum as long as elevation of temperature persists.
4. Covering the limb with absorbent cotton, steeped in solution of chloral hydrate and ammonia until eruption ensues.
5. Rest in bed during one month after the last increase of temperature caused by the phlegmasia.
6. Wearing of an elastic stocking, or something similar, from the very first day that patient leaves the bed.

The prophylactic treatment consists:

1. In careful antisepsis during confinement, especially in women predisposed to albuminuria and hemorrhages.
2. Preventive injections of antistreptococcic serum in cases where a previous confinement was complicated by phlegmasia or in women in whose families the disease is, so to say, hereditary.—*Deutsche Med. Zeitung*, No. 77, 1899.

VICARIOUS PHILANTHROPY.—Dr. H. V. Sweringen, in a letter on Physicians and Charity, published in the Cincinnati *Lancet-Clinic* for December 16, discoursing on the simple methods so often practiced by the tender-hearted laity of being charitable at other people's, and especially physicians', expense, says: "I have frequently been called into wealthy Christian (?) families whose annual foreign missionary contribution was quite respectable in amount, to treat the 'hired girl' or 'servant.' Before seeing her, the dear good Christian mistress of the house was certain to remind me that the girl was poor, entirely destitute, an orphan, had no one to depend on but herself; that her wages were barely sufficient to keep her when able to work, to say nothing of her inability to earn any while sick, etc.; that she was an excellent girl, of good moral character, and a *splendid worker;* that she was very desirous of keeping her, for good girls were very scarce now, but that she could not possibly keep her if she was going to be sick for any length of time. 'Poor girl! I feel very sorry for her, but I don't know what I'm to do with her sick on my hands; if she is to be sick more than a day or two, doctor, can't she be taken to the hospital, or to the county asylum? I can't afford to keep her if she is sick. You do what you can, for her, doctor; try and get her up as soon as possible, and she may be able to pay you some day.'

"Thus are the remarks of the mistress ostensibly in the behalf of the 'poor hired girl,' but it does not require a very great strength of the imagination to conclude that they are made principally in her own behalf, with the view of getting as much service from the doctor as possible, with the implied understanding that she would be in no way responsible for the same, and with the implied hope that the doctor would not expect the 'poor hired girl' to be.

"The good (?), kind (?), charitable (?), Christian (?) mistress thus succeeds in securing professional services, and, perhaps, also the medicine, if the physician furnishes his own remedies. In every case, however, into which my curiosity prompted me to inquire every cent of money paid for medicine, and minute of time lost by sickness and failure to work was deducted from the 'poor girl's' wages when, after recovery, she resumed her work. The physician may be as impecunious as his patient, but that makes no difference to these charitable (?) Christians (?). Such Christianity is damnable. Hell is full of just such Christians. They are so close that it would be impossible to introduce a greased flax seed into their 'recti rectorum.'

"No wonder girls go to the bad when they find so little of the milk of human kindness in the Christian families!

"I used to think it was the 'whole thing' to give a dollar to the tune of 'Greenland's Icy Mountains,' but I will never give another d—d cent to it until America's abused, poverty-stricken hired girls are better treated by our Christian (?) civilization (?). I would much prefer to contribute five dollars to that other tune—

> "Alas! for the rarity
> Of Christian charity
> Under the sun;
> Oh, it was pitiful,
> Near a whole city full,
> Home she had none."

—*New York Med. Journal.*

Catheter Paste.—For lubricating catheters, Kraus (*Oesterr. Zeits. für Pharm.*) recommends the use of a paste of the following composition: Tragacanth, 2.5; glycerin, 10; phenol water (3 per cent.), 90. This paste facilitates the passage of the catheter, and is easily washed off in warm water.—*Med. Review.*

Substitute for Poultices.—M. J. Wilbert (*Am. Jour. Pharm.*) suggests the following formula for a substitute for poultices: Kaolin, 1000; glycerin, 1000; boric acid, 100; oils of peppermint and wintergreen, each 1; oil of eucalyptus, 2. Pass the kaolin through a No. 60 sieve to free it from impurities, and heat to 100 deg. C. for an hour or more to sterilize it; then add the glycerin and continue to heat for thirty or forty minutes, stirring the mass occasionally with a spatula until a smooth, creamy mass is obtained. Remove the source of heat, and when the mass is nearly cool, add the boric acid and the oils; mix thoroughly, and preserve in tin or glass boxes, which are sufficiently tight to prevent the absorption of moisture from the atmosphere. Similar preparations have been sold in America under the names "Antiphlogistine" and "Antithermaline."—*Pharm. Jour. and Med. Review.*

A Mathematic Theory of Heredity.—Theories of heredity have a fascination for the biologist, and no less for the thoughtful general reader. Mathematics bears no small part in most of them, but it is usually applied to the statistic treatment of the subject. To find an analogy between the laws of heredity and those of analytical geometry is a novel proceeding, and this is what is done by Dr. Felix Le Dantec in a recent lecture at the Sorbonne, in Paris, which is published as a leading article in the *Revue Scientifique* (January 13). Dr. Le Dantec is not the discoverer of the interesting analogy that he treats of, but he has applied it in an entirely new and fruitful way to explain the laws of heredity, or rather, perhaps, to indicate the line along which we must seek to elucidate those laws. In the first place the author makes this striking statement of the complexity of the animal body, which is built by natural growth in a few years:

“Suppose that you had to describe minutely a given man; and when I say ‘minutely’ I mean with such minuteness that the person to whom you describe him could reconstruct him identically, as a man is built up from the ovum—as heredity reconstructs, in short.

“To make this description complete, you may divide the body of an individual into small cubes, a millimeter ($\frac{1}{25}$ inch) on each side, and if you have made a complete description of all these cubes, it will be sufficient, in order to reconstruct a man similar to the original, to make as many cubic millimeters, similar and similarly arranged. The volume of a man being about 80 liters, you will have to define the location and structure of 80,000,000 of these cubes. This seems a somewhat complicated matter; but within each cubic millimeter you will find a complexity almost as great, for each contains not less than a million of cells. That makes at least 80,000,000,000,000 cells whose structure and location you will have to define. And note that a cell is far from being a simple element, and that even if you know exactly the molecular structure of its different constituent elements it would be no small task to describe them exactly.

“This gives some idea of the work that you would have in giving the elements indispensable to the construction of a man similar to your model. It is true that these indispensable elements would be sufficient, and that the man thus described would be described fully; in other words, your description would embrace all the characteristics of the person described; for although it would not include explicitly the length of his neck, the shape of his nose, etc., it includes implicitly all these larger characteristics. * * *

“But although these elements are sufficient, it must not be forgotten that they are indispensable, and that the absence of a single one of them would suffice to make it impossible for the manufacturer to fulfil his task!

“And, nevertheless, the egg reproduces all this; the microscopic egg contains all this information within itself! All these characteristics are represented therein, since we know that if a single one of them is wanting, the man can not be completely constructed.''

Dr. Le Dantec then proceeds to unfold his mathematic analogy. Mathematicians, he reminds us, can not represent algebraically any arbitrarily drawn curve; but, given an algebraic equation, it can be interpreted to mean certain space relationships, and a curve can therefore be drawn to represent it. Moreover, this particular curve represents this particular equation and no other, and the equation corresponds to every minute section of the curve. Two different equations can not represent two curves that have any finite section in common, no matter how small this may be. If the equation be altered in such a way that a small section is changed, the whole curve changes with it. Now, what bearing have these mathematic facts on biology? Let us hear M. Le Dantec again. He says:

''Is there not in all this something distantly comparable to the phenomena of heredity? An egg, a simple cell, is sufficient to determine an agglomeration formed of 8,000,000,000,000 cells, just as a finite, very small segment of a given algebraic curve is sufficient to determine the whole curve, infinite in extent.

'' We shall abuse this comparison if we consider as rigorously determined in the egg the adult that develops from it, since it is certain that the environment will have a profound influence on its structure. I shall not fall into this fault of reasoning, but I shall draw from the preceding comparison a very important conclusion, by comparing the algebraic curve not, as has been done by some, to the evolutional history of man, but rather to the man himself, considered at a given moment, with his 80,000,000,000,000 cells.

'' The curve under consideration has the following properties:

''(1) All its segments, in whatever place, are different, at least in position; but

''(2) Nevertheless, each of them is sufficient to determine the entire curve; and

''(3) If one of them varies, all the others vary correspondingly.

'' It would not be unreasonable to apply rigorously to man the three preceding propositions:

''(1) All the cells are different; but

"(2) Nevertheless, each suffices to determine the whole man; and

"(3) If one of the cells varies, all the others vary in corresponding fashion. . . . . . .

"It is not owing to my faith in a simple mathematic comparison that I announce the principle: 'Each cell of man's body suffices to determine the whole man'; on the contrary, my conviction of its truth, acquired in advance, has led me to make the present use of the comparison, and has shown me how valuable this comparison is."

But M. Le Dantec pushes this interesting analogy still further. Mathematicians recognize what they call "families" of curves (the very name implies the dim recognition of a biologic likeness). Such, for instance, would be all the circles having a common center, all the ellipses having a common axis, or any group of curves of the same type having some feature in common. These may be regarded as developed from one typical member of the family by varying some one feature. To such a family of curves M. Le Dantec likens man at his different ages. One variable feature in this case is the time; and as this flows on, the curve corresponding to a man at one age passes gradually into that of another age, without ever losing continuity. Another variable feature is that introduced by environment, which likewise modifies the curve.

Now, says M. De Lantec, does a segment of one of these curves resemble or represent the corresponding segment of another? Assuredly not. They are related; they correspond, and one is developed from the other; but they do not necessarily look at all like one another. The corresponding segments of a family of concentric circles have totally different lengths and curvatures. In like manner, he says, it is absurd to say, as some do, that adult characteristics such as the curvature of the nose or the length of the neck are represented in the egg, as those assert who put forward the theory of "representative particles." The whole man is defined by any one of his cells and by any one of his parent cells; but there is no representation about it. The relationship in the case of the mathematic curve is defined algebraically by an equation. He who shall tell us what corresponds to this equation in biology will have solved the mystery of heredity.—*The Literary Digest.*

NEURALGIA EPIDEMICA (LOCALIS).—From August 10 to November 10, 1898, Dr. Wille observed in Oberdorf (Bavaria) more than fifty cases, and the observations of neighboring physicians, having to treat identical cases, brings its number to 112.

All disturbances of sensibility, the origin of which could be ascribed to a local, or another etiologic or pathogenic factors of moment were excluded, and beyond this the cases of neuralgia remain unelucidated with regard to their primary, morbid cause, for Dr. Wille himself states his inability to furnish one, though he has been attacked himself, and notwithstanding this he is unable to discover the exciting cause, perhaps a specific one, of this "local" neuralgia epidemic, which he considers belonging to an infectious disease.

But Dr. W. tries to establish the predisposing influence of the usual collateral and accessory circumstances as playing a role in this epidemic, and to justify his assumed idiopathic *genesis*, he conclusively shows that he could not have confounded the positive facts with herpes zoster, nor primary, multiple neurites, nor malaria larvata, nor influenza.

Concerning the influence of the locality, Dr. W. shows that the relatively largest morbidity appeared where the subsoil was humid and marshy. As to the meteriologic conditions, wind, fog and thunderstorms, had a noticeable influence on the course of the neuralgic morbidity, the influence showing itself some nine to twelve days after the appearance of the said phenomena, and that the curve of the atmospheric pressure after about a fortnight showed a pretty good corresponding accord with the neuralgic frequency. The relative humidity of the air after sixteen days showed yet a noticeable accord with the curve, while a comparison of the temperature with the morbidity for for the single days, showed no corresponding accord and only a slight one for longer periods, giving, at all events, but uncertain results.

The female sex was decidedly more subject to get the disease —57 per cent. women and 43 per cent. men. Persons whose age was from 20 to 40 showed more than half of all attacks, viz., 62—55.3 per cent., of which percentage 60 per cent. belonged to the female and 40 per cent. to the male sex. The age from 10 to 20 years showed a trifle over 10 per cent., of which 75 per cent. died, while, on the contrary, persons of the age of

51 to 60 years, with 16 cases, the male sex shows a percentage of 70.

According to Dr. Wille the reason why the female sex was attacked in a larger number lies in the anatomic conditions and the physiologic function of the female genital sphere, which, through interfering development-processes during puberty, and frequent, periodic return of circulatory and nervous changes in the genital apparatus, and especially in consequence of numerous pregnancies and births, unfettered by artificial barriers, and accompanied by profuse hemorrhages, generally lead to a series of constitutional anomalies and neuroses and create ample disposing moments. Considering the different callings, Dr. Wille states that the agricultural, especially dairy-pursuing population, furnishes a percentage of nearly 77 with regard to the morbidity, while trade and craft people show nearly 20 per cent., and with the so-called learned professions the percentage amounts to 35.

The influence of constitutional diseases as *causa morbis* is a very probable one in a portion of all cases, amounting to 12 per cent. The neuropathic disposition for neuralgia could be shown in 7 per cent. as an auxiliary cause. Concerning special occasional causes, the anamnesis failed to give reliable results. —*Münchener Medizinische Wochenschift*, Nos. 33–35, 1899.

CLASSIFICATION, ORIGIN AND NOMENCLATURE OF INCOMPLETE CONDITIONS WITHIN FEMALE SEXUAL ORGANS DURING GESTATION.—Of incomplete internal sexual organs, no less than fifty different species can be distinguished.

The variability in this respect in the female sex is, therefore, far greater than in the male sex. But if, on the one hand, the several formation anomalies of the female canal are easily recognized from an anatomic standpoint, on the other hand, our knowledge concerning their causes is, as yet, obscure.

With the intention of clearing up this obscurity somewhat, Dr. F. von Winckel has made elaborate investigations. He begins, in his explanations, to criticise, as incorrect, the nomenclature given by Kussmaul, Nagel and Gebhard.

He very elaborately enters into the embryonal development stages, and attaches significance to the malformation of the ligamentum rotundum, where it is inserted in the canal of

Wolff. If the canals of Muller are primarily unequal, or if this is the case with the ligamenta rotunda (perhaps showing hyperplasia on one or both sides), the *uterus*, or rather one-half of the uterus, is liable to be drawn towards its anterior portion, resulting in an acquired *obliquitas uteri intra-uterina*, etc. Dr. von Winckel concludes by an analytic classification of all causes.

A: local causes:

1. Irregularities in the formation of the abdominal wall (hernia umbilicalis congenita; fissura pelvis et vesicæ, etc.). Abnormally short amniotic filaments; absence of the placental artery, etc.
2. Inflammatory processes: fetal peritonitis; nephritis; oophoritis; pelviperitonitis.
3. Malposition caused by tumors, e. g., cystic kidneys, etc.
4. Pulling, pressure, torsion, proceeding from neighboring organs: bladder, ureter, canal of Wolff, *ligamentum teres*, vessels and nerves of the uterus.
5. Abnormal germs in the septum.
6. Absence of vulva.

B. General Causes:

7. Constitutional causes: As anemia, clorosis, lues, rachitis congenita; hyperplasia of the vascular system.

8. Central-nervous ones: Hydrocephalus, encephalocele, anencephalus, and other cerebral anomalies. Dr. von Winckel is of opinion that the causes mentioned sub 4 are by far the most frequent ones.

In the nomenclature of the formation-anomalies of the femal sexual organs Von W. wants the designations uterus didelphys, uterus bipartitus, bifidus-biloctelaris, bicameratus, uterus fetalis, bicornis, uterus fetalis imperforatus, etc., omitted altogether, as all these expressions lead only to misunderstandings.

Dr. L. Pick, in reviewing Dr. von Winckel's labors, says very correctly: A right and absolutely logic nomenclature which gives as little play-ground to the arbitrary divagation of an author as possible, seems, indeed, of no small signification for the understanding in this field of investigation in the future, and we add, in any other, too.—*Deutsche Medizinal Zeitung*.

THYROID EXTRACT.—Mahon and Babcock contribute to the *American Journal of Insanity* the results of the use of Thyroid extract in 1032 cases of insanity. They conclude:

1. That the dose of the extract depends entirely on the individual case. In some cases twenty-five grains three times a day will be necessary to bring about a circulatory or temperature reaction; while in others the same results may be had with the use of five grains three times daily. Each case must be a law unto itself.

2. It is essential that the patient should be placed in bed to obtain the best results, and he should be continued there during the entire treatment and for a week following its discontinuance.

3. The treatment should be continued for at least thirty days.

4. We should not be discouraged by failure in the first administration, but should resort to two, three, or more trials, if necessary.

5. The most gratifying results in thyroid treatment are to be obtained in cases of acute mania and melancholia with prolonged attacks, perpetual and climacteric insanities, stuporous states and primary dementia, particularly where these forms of mental alienation do not respond to the usual methods of treatment.

6. A high temperature reaction is not essential, as the average maximum temperature in the recovered cases among men was 99.6 deg.

7. Physical improvement is the outcome in most cases, whether mental improvement takes place or not.

8. The proportion of individuals who recover under thyroid treatment and then relapse is less than the proportion that relapse after recovery from other methods of treatment. In their own series of cases, only one patient who recovered has relapsed.—*Therapeutic Gazette*.

THE TREATMENT OF ITCHING.—In *Treatment* of October 26, 1899, WILLMOTT EVANS, in writing upon this theme states that among curative agents baths take the first place. An ordinary bath will contain about thirty gallons of water, and in this amount of water the quantities mentioned below may be dissolved. The most efficient baths are those containing alkalies, and a quarter to half a pound of the carbonate or bicarbonate of sodium may be used, or the corresponding potassium salts will act equally well. A borax bath is very valuable, and one to four ounces of the salt may be dissolved in the thirty gallons of water; or potassa sulphurata may be employed, the same amount being used. Starch (one pound) or bran (two pounds) baths are often useful, and they are a little more sedative than alkaline baths; or the starch bath may be combined with the alkaline one. A linseed-meal bath is best made by boiling a pound or two of the meal in two or three quarts of water, and then pouring it, with or without fermentation through muslin, into thirty gallons of water in the bath. In severe cases the continuous bath may be employed with much benefit, and the patient can take his meals and sleep in the bath; if necessary, this may be continued for several days, or even weeks.

Turkish or vapor baths suit some cases exceedingly well, and the benefit is probably chiefly due to the free sweating which is produced, and even very hot water may give great relief.

In addition to or in place of baths, either lotions or ointments may be applied for the relief of itching; but when the pruritus is general, lotions are more cleanly, and are generally preferred. When any excoriations are present, or the mucous membranes are affected, great care must be exercised in the choice of the local application. Of all lotions, those containing carbolic acid are the most useful, and the best strength is one of the acid to sixty of water; or the sedative action of alkalies may be added, as in the following prescription:

℞ Acidi carbolici liquefacti, ʒ j.
Liquoris potassae, ʒ ss;
Aquae, q. s. ad ℥ x.
Misce, fiat lotio.

Or borax may be combined with the carbolic acid, as in this formula:

℞ Acidi carbolici, ʒ j;
Sodii biboratis, ʒ j;
Aquae, q. s. ad O j.
Misce, fiat lotio.

The other lotions are numerous which have been employed in the treatment of pruritus, but few of them need be mentioned. Dilute acetic acid, or vinegar mixed with an equal quantity of water, is useful; as is also a weak solution of chloroform in alcohol and water, as in this prescription:

℞ Chloroformi, ʒ j;
Spirit. vini rectificati, ℥ x.
Aquae, q. s. ad O j.
Misce, fiat lotio.

Various lotions containing lead may be used, as:

℞ Liq. plumbi subacetatis, ʒ ij;
Glycerini, ℥ ss;
Aquae, ad ℥ x.

Tar lotions, especially if alkaline, may prove beneficial, though the staining of the clothes which may result from its use, and its marked odor, are often objected to by the patient. The following is a convenient formula:

℞ Liq. picis præparati, ʒ ij;
Liq. potassæ, ʒ iij;
Spirit. vin. rect., ad ℥ ij.
Of this two or three drachms may be mixed with a pint of water.

Lotions are certainly preferable if the extent of the skin affected with itching is very large; but if the area is small an ointment is a much more convenient preparation.

An ointment containing carbolic acid is perhaps the most useful; it may be compounded as follows:

℞ Acidi carbolici, gr. v ad gr. xxx:
Unguenti zinci oxidi, ʒ iv;
Unguentum paraffini, q. s. ad ℥ j.
Fiat unguentum.

Immediately after carbolic acid Evans is inclined to place ichthyol, and it is especially useful if the part is inflamed. A very convenient ointment is that in the following prescription:

℞ Ichthyol ℥ ss ad ʒ iij;
Pulv. calaminæ, ʒ ij;
Unguentum paraffini, ad ℥ j.
Misce, fiat unguentum.

Resorcin is also very useful in some cases, and may be prescribed as follows:

℞ Resorcin, gr. xv ad ʒ j;
Zinci oxidi, ʒ ss;
Unguentum paraffini, ad ℥ j.
Misce, fiat unguentum.

Beta-napthol can be used as an ointment as follows:

℞ Betah-naphthol, gr. xx;
Unguentum paraffini, ℥ j.
Misce, fiat unguentum.

Ointments containing mercury are often of value, but they should never be employed when a large surface of skin needs to be treated, for the risk of mercurial poisoning is by no means small. The following formulae are suitable:

℞ Hydrargyri ammoniati, gr. xxx;
Pulv. zinci oleatis, ʒ j;
Paraffini mollis, ʒ v;
Paraffini duri, q. s. ad ℥ j.
Misce, fiat unguentum.

℞ Ung. hydrarg. nitratis diluti, ʒ j;
Unguentum paraffini, ad ℥ j.

Among the local applications may be mentioned a cut lemon rubbed on the affected part.

Internal remedies directed against the pruritus may also be administered; carbolic acid is often useful, and may be given in the form of pills containing from half a grain to one grain of the carbolic acid, and one pill may be taken three times a day.

The nitrate of pilocarpin may be given in doses of one-tenth of a grain twice a day. Cod liver oil often acts well, and the effect does not seem to be wholly due to its action on the general health.

Local pruritus often needs special treatment, and the several forms may be briefly considered. In all local forms of itching a local cause should be most carefully sought, for it is almost always present.

Pruritus Ani.—Any hemorrhoid or fissure must be treated, and the condition of the portal circulation especially demands attention. In addition to any of the ointments already mentioned, a cocain suppository, containing one-sixth of a grain, often has a striking result; or the following may be used:

℞ Morphinæ hydrochloratis, gr. 1-4;
Cocainæ, gr. 1-6;
Ol. theobromæ, ad gr. xv.
Fiat suppositoria.

Pruritus scroti, when not due to pediculi or other obvious causes, is often associated with a local hyperidrosis, and the use of a dusting powder, such as one composed of equal parts of oxide of zinc and starch, will relieve it; or any of the ointments already given may be used.

Pruritus vulvæ is most commonly due to pediculi pubis, or to the irritation of diabetic urine. In the latter case the local pruritus may be much abated by the use of an ointment which will protect the skin and mucous membrane from the irritation of the sugar. For pruritus of the vulvæ arising from no discoverable cause, an ointment of carbolic acid, such as has already been mentioned, will prove of service.—*Therapeutic Gazette.*

THE TREATMENT OF WARTS.—Gastel (*Journal des Praticiens*, No. 34, 1899), states that warts are due to a specific bacterium and are very markedly autoinoculable; but that they may readily be destroyed by all caustics, either applied directly to the surface of the papilloida or to the wound left after its avulsion. Nitric acid is placed first in the long list of cauterants. A wooden toothpick is the best applicator; the surrounding skin being protected by a coating of collodion.

Anesthesia is satisfactorily accomplished in pusillanimous patients by chloride of ethyl. The galvano, or thermocautery is an excellent instrument for the total destruction of these growths. Kaposi recommends the following pastes as especially serviceable for the treatment of warts on the back of the hands and on the face:

Flowers of sulphur, 20 parts.
Glycerin, 50 parts.
Diluted acetic acid, 10 parts.

A 10 per cent. salicylate ointment is efficacious for the treatment of small warts. To this may be added resorcin. The plaster should be removed every two or three days, the wart being scraped and the plaster applied again. A very common form of treatment consists in the use of salicylic collodion, made up of salicylic acid one part and flexible collodion eight parts. This is painted over the surface of the wart, and the application renewed every time the pellicle thus formed is rubbed off. Sublimate collodion is sometimes used, but it is extremely irritating. This is made of

Sublimate, .2 parts;
Collodion, 10 parts.

The smooth, flat warts of children require less severe application than the rough, hard warts of adults. The seborrheic warts of the aged, made up of an epithelial layer placed on a papillary overgrowth, become so frequently the starting points of cancer that they should be treated promptly. Cauterization or soap-poulticing, followed by the application of the salicylate ointment, will usually be found efficacious. Where these warts are large and vegetating, curetting, followed by cauterization is always the best treatment.—*Ibid.*

THE LEPER.

Unfavored of God's kind,
And set apart, a curse;
A living death for men to pity,
As they shudder at the worse
Than sin, or pain, or shame
Of *It;* for can a name
Be borne by one of these?

Not spotted white, nor snowy clean,
As Bible tales remark it;
But, bursting through a boiling skin
Of lumps and bumps, a thickened mass
Of bronzed and blackened human kin.
With here and there a spot of brown
Or lighter hue, while over all a tint of red
By Nature's thrown, as if to hide the frown
Which masks the soul of those
Who bear the burden of the blight.

Nor king nor serf the scourge hath spared,
And as the ages into æons run,
These sightless, voiceless human parodies
Will breathe the tones of the Unblest,
Accursed by all, marked by Fate
As victims of the great Unrest,
The Morbid in the True, too late
To save their souls for better things.
And so the fell decree makes members
One by one to fall, until at last
The end finds semblance only of a past,
A trace alone of kinship to the race
Which bore it, in this, a mass
Of tissues, human once, but now
Distorted, framed and bound in shapes
Fantastic in their frightful symmetry,
And shorn of everything but form.

—Isadore Dyer, M. D.

Medical News Items.

The Journal regrets to note the death of Mrs. J. A. Storck, which occurred in the month of February. Mrs. Storck had been ill for some time and the Journal tenders heartfelt sympathy to her husband, Dr. J. A. Storck, one of our esteemed collaborators.

MARRIED.—Among the benedicts of the month just past the JOURNAL felicitates Dr. H. B. Gessner and Dr. John B. Elliott, Jr., both of New Orleans, and Dr. Ernest House, of Ferris, Texas.

DIED.—Dr. M. J. Olivier, of Berwick, La., died January 26. He was one of Berwick's most prominent and influential citizens and was widely known throughout the parish of St. Mary.

DR. WILLIAM CARSON, aged eighty-four years, a native of Cavan, Ireland, and a resident of New Orleans for the past fifty years, died February 3.

DR. WIRT JOHNSON, of Jackson, Mississippi, died last month; not only the profession but the entire State of Mississippi has lost a man of much worth.

THE SMALL-POX SITUATION IN LOUISIANA is greatly improving and the district medical inspectors are doing good work.

MISSISSIPPI PHYSICIANS are to pay a "privilege tax" hereafter. This means that a tax has been placed by the cities and legislature as follows: $10 for physicians practicing in cities and towns of 3000 people; $5 for smaller towns and $2.50 for country practitioners.

THE STATE BOARD OF MEDICAL EXAMINERS have scored another victory over Fowler, the ubiquitous quack of Algiers and Gretna. He has previously been fined, but on February 9 he was brought up for contempt of court on two charges, which were sustained. In each instance he was fined $50 or ten days' imprisonment.

THE MISSISSIPPI STATE MEDICAL ASSOCIATION will hold its next meeting in Meridian, on April 18, 19, 20, under the presidency of Dr. R. E. Jones, with Dr. J. R. Tackett as secretary.

PROFESSOR AND PRIVY COUNSELLOR DR. WILHELM KONRAD RÖNTGEN, of Würzburg, has been called to Munich as professor in ordinary of the university, to the chair of "Experimentalphysik" (experimental physical science) and director of the physical institute of the philosophical faculty, and also as conservator of the physico-metronomic institute of Bavaria.

THE *Stylus* is the name of a neat, new journal from St.

Louis, with Dr. William Porter as editor. The intention of this publication is to make it a compendium of reports on original hospital and clinical work.

THE LOUISIANA STATE BOARD OF HEALTH, at its regular meeting, February 13, elected the following medical officers:

Quarantine Physician, Atchafalaya Station, Dr. Geo. H. Douglas. Medical Inspector, Livingston, Guatemala, Dr. J. B. Bonney. Medical Inspector, Belize, Brit. Hond., Dr. C. W. Knight. Medical Inspector, Pt. Lima, Costa Rica, Dr. Will H. Woods. Medical Inspector, Puerto Cortez, Span. Hond., Dr. W. K. Fort. Medical Inspector, Bluefields, Nic., Dr. L. A. Wailes. Medical Inspector, Bocas del Toro, U. S. C., Dr. Allen Jumel.

This leaves the positions of Quarantine Physician at the Rigolets Station and the Medical Inspector at La Ceiba, Span. Hond., open to physicians of Louisiana who are experienced in yellow fever.

Applications should be filed before March 12, at the State Board of Health office, New Orleans.

DR. W. K. SUTHERLAND, of Mansfield, La., has returned from a European trip.

DR. C. J. GREMILLION, of Cottonport, La., has moved to Alexandria.

THE MEDICAL COMMITTEE OF THE UNITED CONFEDERATE VETERANS desires to make a feature of the Louisville Reunion, May 30, 31, June 1, 2, 3, the assembling and entertainment of physicians who were surgeons of the army and navy of the Confederate States, as well as those who were veterans and sons of veterans. All interested are requested to send their names to Dr. Preston B. Scott, 1514 3d street, Louisville, Kentucky.

THE AMERICAN DERMATOLOGICAL ASSOCIATION will meet at Hotel Gordon, in Washington, May 1, 2, 3. The topic for general discussion will be Classification and Clinical Features, Etiology and Pathology, and the Treatment of Malignant Diseases of the Skin.

THE ORLEANS PARISH MEDICAL SOCIETY AND THE NEW ORLEANS POLYCLINIC have sent resolutions of protest against the Gallinger antivivisection bill.

DR. H. R. CARTER, of the Marine Hospital Service, was in Washington at the last report.

INTERNATIONAL CONGRESS OF MEDICAL ELECTROLOGY AND RADIOLOGY.—At the request of the French Society of Electrotherapy and Radiology, this Congress is to be connected with the International Congress of 1900, and will take place in Paris, from July 27 to August 1, 1900.

A commission, which is composed of: Messrs. Weiss, Professor at the University of Paris, President; Apostoli and Oudin, Vice Presidents; Doumer, Professor at the University of Lille. General Secretary; Moutier, Secretary; Boisseau du Rocher, treasurer, and of Messrs. Bergonié, Professor at the University of Bourdeaux; Bouchacourt, Branly, Professor at the Catholic Institute of Paris; Larat, Radiguet, Villemin, Surgeon of the Hospitals of Paris, has been asked to assure its organization.

Further information may be had of Prof. E. Dovmer, General Secretary, 57 Rue Nicolas-Leblanc, Lille.

Applications for membership are to be sent to Dr. Moutier, 11 Rue de Miromesnil, Paris.

NOTICE.—The report has been circulated that the New Orleans Polyclinic has been suspended on account of small-pox in New Orleans. This statement is absolutely false. The Polyclinic has had a continuous course since November 20, and will continue until May 12. The small-pox situation in New Orleans has at no time justified any apprehension on the part of physicians attending the Polyclinic or on the part of those who might wish to do so.

ISADORE DYER, M. D.,
February 24, 1900. *Secretary New Orleans Polyclinic.*

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

An American Text-Book of Surgery for Practitioners and Students. Edited by WILLIAM W. KEEN, M. D., and J. WILLIAM WHITE, M. D. Third Edition, thoroughly revised. W. B. Saunders, Philadelphia, 1899.

The great popularity of this text-book of surgery is attested by the fact stated in the preface that of the two former editions nearly 29,000 have been sold, the first edition being issued in 1892.

This last revision has included all the chief advances and improvements in surgery of recent times. A few inaccuracies may be noticed, such, for instance, as that on p. 874, "Keen and others prefer to distend the bladder with air filtered through cotton," when the credit of this suggestion really belongs to Bristow, although Keen did have much to do with popularizing the plan. (Bristow, by the way, has called attention to the absurdity of filtering the air when the viscus is immediately laid wide open in this same atmosphere). A few omissions also of, to our mind, valuable methods are to be noted. Thus, on p. 732 *et seq.*, the only operation for inguinal colostomy described is that of Maydl. The operation known as the skin-bridging operation of Bidwell is so simple, expeditious, safe and satisfactory that it deserved some mention. Nowhere further do we find any reference to the suggestion of Gersumy for giving control over the artificial anus. But we hesitate even to mention these points of really minor importance in a work which is so comprehensive, so accurate, and withal so reliable a guide as this will prove to be.

PARHAM.

A Manual of Surgical Treatment, by CHEYNE AND BURCHARD, in six volumes. Volume II, Lea Brothers & Co., Philadelphia and New York, 1899.

This is the second volume, the first having been published in June, 1899. The first volume treated of the general surgical diseases and of anesthetics, the present one of the surgical affections of the tissues, including the skin and subcutaneous tissues, the nails, the lymphatic vessels and glands, the fasciae, bursae, muscles, tendons and tendon sheaths, nerves, veins and arteries, and of deformities. The following statement in the preface to the second volume indicates the general plan of the work: "In the ordinary text books for students, symptoms and pathology are gone into most fully, and only the salient points in the treatment are indicated. We, on the other hand, have endeavored to give only the salient points in the symptoms and pathology, and have gone fully into the question of treatment."

The aim of the book is to give detailed directions for treatment, especially the after treatment, and the methods of treatment found best in the experience of the authors have been given rather than a discussion of of the various methods suggested by different men. We believe these volumes will be of great service to the surgeon and practitioner on account the systematic manner in which the directions for treatment are given. This is really the strong point of the book, since it is assumed that the reader is familiar with the nature and diagnosis of disease and with its pathology and symptoms, these being touched upon only in so far as may be necessary to render intelligible the principles upon which the treatment is based.

PARHAM.

General and Local Anesthesia, by AIME PAUL HEINECK; G. P. Engelhard & Co., Chicago, 1900.

There is no preface to this little book, but a notice from the publishers to the editors speaks of the volume as one "which we believe is practically the only special work on the subject in the English language." Perhaps,

then, if the publishers had been aware of the excellent works of Buxton, Turnbull, Foy, and others, which are all special works on anesthesia, they would not have attempted the task of getting out another special work. But one should not blame the author for this blunder, since he makes no such claim, and indeed puts on his title page a very appropriate quotation from Dudley Buxton's book. The book will be found useful, as it gives a very good résumé of the subject, but it can not supplant some of the books mentioned, which present the subject in a more comprehensive manner. We find no mention of injection into the larger nerve trunks for regional anesthesia, nor of the later method of Bier of anesthesia by spinal instillation. We think the author is misleading in the following sentence, on page 107: "Extreme caution in the use of cocain is to be employed, when the circulation can not be controlled. First inject one centigram of the drug; if no untoward symptoms occur there is no idiosyncrasy. You can then inject more." The book has one omission which is reprehensible, it has no index, which is inexcusable in any book published at the present time.
PARHAM.

Operative Surgery, by JOSEPH D. BRYANT, M. D.; Vol. I, Second edition; D. Appleton & Co., New York, 1899.

We heartily recommend this volume, not so much to beginners, but to advanced students and practitioners. It is certainly one of the most complete and most up-to-date books on the subject. The illustrations are numerous and especially clear and comprehensive.
LARUE.

Recollections of a Rebel Surgeon; or in the Doctor's Sappy Days. By F. E. DANIEL, M. D. Von Boeckmann, Schutze & Co., Austin, Texas, 1899.

We of the southwest have both felt and heard Brother Daniel's pen, and whenever it has been needed, it has been ready to champion or attack. Among the Nestors of medical progress, Daniel has stood in the fore and with such others as the one to whom these valedictory stories are dedicated—Swearingen.

There is little of pretensiousness in Daniel's book, but it is full of the man and are just what they pretend to be—a retrospective, casuistic sketch of thirty years back. Each story links the present with a generation gone and the pathos sends a line of cadences throughout the book. We need not mention a single one of the tales, for that would only spoil the reading, and that every Southern doctor, at least, should give them.

DYER.

Twentieth Century Practice of Medicine, Edited by W. L. STEDMAN, M. D., Vol. XVII. Syphilis and Leprosy. William Wood and Company, New York, 1899.

Perhaps no more valuable contribution to the literature of these two subjects has appeared hitherto in the English language than the one before us. The subject of syphilis is handled exhaustively from the standpoint of the acquired disease, by Lang, of Vienna; of the inherited disease, by Jonathan Hutchinson, of London. Morrow, of New York, writes upon the second subject. That syphilis is treated from a standpoint of modern thought is particularly impressed upon us by a few remarks bearing upon the classification of the varieties of this disease.

Says Lang: "Ricord taught, as we know, that the constitutional effects first became manifest in the superficial and later in the deeper (internal) organs and tissues, and he accordingly introduced the seductive terms 'primary,' 'secondary' and 'tertiary' syphilis—expressions which are still in use at the present time, and which result merely in confusing the inexperienced and the less well-informed. We can not, therefore, sufficiently emphasize the fact that in reality this remarkable sequence does not always occur. If we treat of the disease of the various organs and disease in a certain order, it is understood that this is done only as a matter of convenience."

We congratulate Dr. Lang on this bold statement which we have taught for the past six or eight years, and of which the above is the first authoritative position we have seen taken in print.

The writer also takes the position that many cases of syphilis get well spontaneously, while the fact of the necessitous treatment is evidenced by some twelve pages of selected formulas. Dr. Hutchinson writes in his usual felicitous style on the inherited disease.

Morrow's position as a leprologist entitles his work in this volume to the fullest consideration. It is exhaustive in many respects, being a review of every phase of the subject up to the present time. More than all, the text carries the strong personal ideas of the writer. We can not, however, let a misapprehension of Dr. Morrow pass unchallenged; he argues the recrudescence of leprosy in Louisiana because of the greater numerical showing in the cases of this disease observed in the past twenty years. We believe that leprosy has existed for over a century in Louisiana, unreported, largely unnoticed, until the work of Dr. Joseph Jones, in 1878, Blanc, in 1888, and ourselves, in 1895-1898, have made the disease recognized as it should have been long before.

DYER.

PUBLICATIONS RECEIVED.

Transactions American Orthopedic Association, 1899.

Baking Powders, by Charles A. Catlin, Ph. B. & C.—Rumford Chemical Works, Providence, R. I., 1899.

A Manual of the Diagnosis and Treatment of the Diseases of the Eye, by Edward Jackson, M. D.—W. B. Saunders, Philadelphia, 1900.

Transactions of the American Otological Society, published by the Society—New Bedford, Mass., 1899.

Progressive Medicine, Lea Brothers & Co., Philadelphia and New York, 1899.

Recollections of a Rebel Surgeon, by F. E. Daniel, M. D.—Von Boeckmann, Schutze & Co., Austin, Texas, 1899.

A Manual of Surgical Treatment, by W. Watson Cheyne, M. B., and F. F. Burghard, M. D.—Lea Brothers & Co., Philadelphia and New York, 1900.

Tuberculosis or Consumption, by H. H. Spiers, M. D., Ravenna, Ohio.

English-French Dictionary of Medical Terms, by H. De Merie.—William Wood & Co., New York, 1899.

Text-Book of Diseases of Women, by Charles B. Penrose, M. D.—W. B. Saunders, Philadelphia, 1900.

A Manual of the Practice of Medicine, by A. A. Stevens, M. D.—W. B. Saunders, Philadelphia, 1899.

Proceedings of the Orleans Parish Medical Society—New Orleans 1899.

Christian Science—An Exposition, by William A. Purrington—E. B. Treat & Co., New York, 1900.

Histology and Pathology, by John Benjamin Nichols and Frank Palmer Vale, M. D.—Lea Bros. & Co., Philadelphia and New York.

Transactions of the American Ophthalmological Society, published by the Society, Hartford, 1899.

The Bubonic Plague, by Walter Wyman, Washington, 1900.

A Practical Treatise on Diseases of the Skin, by James Nevins Hyde, M. D., and Frank Hugh Montgomery, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

The Principles of Treatment, by J. Mitchel Bruce, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

The American Year-Book of Medicine and Surgery, 2 Vols., by George M. Gould, M. D.—W. B. Saunders, Philadelphia, 1900.

REPRINTS.

The Tuberculin Test, and the Need of a More Complete Diagnosis of Tuberculosis—The Climate of Colorado for Respiratory Diseases, by Charles Dennison, M. D.

A Consideration of the Various Forms of Non-Malignant Ulceration of the Rectum—Some Practical Notes Upon Diseases of the Rectum, by Lewis H. Adler, Jr., M. D.

Sarcoma of the Orbit—Albuminuria and Its Relation to Diseases of the Eye, by Alex W. Stirling, M. D.

Hygiene of the Nose, by W. Cheatham, M. D.

The Old New York Hospital, by D. B. St. John Roosa.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR JANUARY, 1900.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	1	2	3
" " Intermittent	1	...	1
" " Remittent	1	...	1
" " Congestive	...	1	1
" " Typho	...	1	1
" Yellow	...	...	...
" Typhoid or Enteric	1	9	10
" Puerperal	1	1	2
Small Pox	24	25	49
Influenza	6	1	7
Measles	25	3	28
Diphtheria	1	...	1
Whooping Cough	...	...	...
Apoplexy	12	10	22
Congestion of Brain	6	3	9
Meningitis	13	2	15
Pneumonia	70	62	132
Bronchitis	29	16	45
Cancer	18	5	23
Consumption	31	29	60
Bright's Disease (Nephritis)	31	24	55
Uremia	3	...	3
Diarrhea (Enteritis)	12	3	15
Gastro-Enteritis	...	4	4
Dysentery	3	...	3
Hepatitis	...	1	1
Hepatic Cirrhosis	6	1	7
Peritonitis	2	3	5
Debility, General	1	3	4
" Senile	27	17	44
" Infantile	3	7	10
Heart, Diseases of	41	19	60
Tetanus, Idiopathic	...	...	...
" Traumatic	3	1	4
Trismus Nascentium	7	12	19
Injuries	20	10	30
Suicide	5	...	5
All Other Causes	91	61	152
TOTAL	495	336	831

Still-born Children—White, 20; colored, 17; total, 37.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 28.28; colored, 44.80; total, 33.24.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.09
Mean temperature	52.
Total precipitation	3.69 inches

Prevailing direction of wind, north.

NEW ORLEANS
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Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

IS FOOD INSPECTION BENEFICIAL TO HEALTH?

BY CHAS. HEITZMAN, M. D., NEW ORLEANS, LA.

With each turn of the medical kaleidoscope is brought to light new theories for old diseases. From the tangent of each prismatic crystal a new germ springs forth. With each succeeding turn new colors and forms are shown tracing the germ through its various vicissitudes of life; how it was once harbored by another host, from thence through the medium of an intermediary bearer, it had at length found lodgment in the animal body. Here begins another history. Until symptoms appear the germ is scarcely given a thought; but when these harbingers appear, then strict search is made, he is isolated and given a name. His name is terror infinitely intensified by the results he is known to produce or the disease begotten. While wonderful activity is displayed in the isolation of germs yet little is done comparatively speaking in the prevention of such diseases. In this age no one doubts the fact that the cause of all diseases is extra organismal and must therefore have an intermediary bearer before it can enter the animal economy, either air, water or food.

Let us consider the latter, food as applied to meat, fish, milk, etc., and we start with the proposition that if these articles are subjected to a constant, rigorous and intelligent inspection, the boundary lines of disease will be changed by such an important preventative factor. The question of food inspection is one of paramount importance to life and health. Without food we can not live; with diseased or unwholesome food we become disease incubators. If this is a fact it is only reasonable that some sort of a guarantee should be forthcoming that the food is as represented, wholesome and nutritious, harmless and innocuous. On no question of social economy is the general public more ignorant than on that of the wholesomeness or otherwise of the food they devour, and on that ground alone, low as it is, it is incumbent upon sanitary authorities to guard them against abuse and injury. Other unsanitary conditions appeal to them through the medium of sight and smell, but when the food is concerned they are generally left to the mercy of the dealer. That the inspection of food, carried on even in an imperfect manner, is of great public utility, must be apparent to those who are placed in a position in which opportunities are afforded for forming a correct and reliable opinion. Large quantities of food affected with different diseases, impurities and decomposition are thus annually withdrawn from the market and rendered harmless by being destroyed. In order that food inspection should be all that public health requires, several conditions must be harmoniously conjoined. There must be legal authority to conduct inspection, and to enable the inspector to enforce necessary regulations. There must be a substantial moral support on the part of the public, both general and official. The inspectors must be competent. If the inspection be honestly and intelligently conducted and the public kept informed as to the work done through official reports, public sentiment will lend strong moral support to this kind of sanitary work. No one thing will create stronger public approval and more general satisfaction than the assurance that the food upon the table is not tainted with disease. Now let us consider some of the more important pathologic conditions that may be and are communicated through the medium of our food supply.

First and foremost stands that inoculable and infectious disease, tuberculosis. To Villemin belongs the honor of having demonstrated its contagiousness (1865); to Robert Koch the honor of having isolated its microbe (1882). There is no disease in existence which attacks so many different kinds of animals. Not one of our domestic animals is completely refractory to it; they simply vary in their susceptibility, and those which under natural conditions escape infection are unable to withstand experimental inoculation. Our poultry yards, even, are often decimated by tuberculosis, and the tribute paid to it by man is enormous. Lydtin's name for it, the "universal panzootic," is indeed an appropriate one. Tuberculosis was known to the ancients—tuberculosis of cattle at any rate. The phthisis of which Columella speaks is certainly our tuberculosis, for he refers to ulceration of the lungs as its last stage, "*Est etiam illa gravis pernicies, cum pulmonis exulcerantur, inde tussis et macies et, ad ultimum, phthisis invadit.*" Although all tuberculous lesions acknowledge the presence of the causative agent—the bacillus of Koch—nothing is more variable than their appearance. Sometimes they take the form of rounded granulations, hardly as big as a millet seed, invading all the organs. Again they are great fluctuating masses, filled with yellow pus, which is thick, grumous, full of calcareous matter and resembles mortar. In other instances the pleuræ, or the peritoneum, are covered with hard glistening grayish-red round neoplasms, with more or less long pedicles, and generally heaped together in clusters of variable size, so as to form genuine polypi, which sometimes attain considerable dimensions. Sometimes, again, the lesions consist of an opaque grayish or yellowish matter infiltrating the tissues. For a long time these varied lesions were thought to be of a very different nature. Laennec was the first to recognize and to proclaim their close relationship. The unity of tuberculosis is admitted everywhere to-day, but for a long time the idea was combated by the school of Virchow, while the doctrine of Laennec, although defended by the remarkable work of Charcot, Grancher and Thaon, was abandoned until quite recently by the large majority of anatomo-pathologists and doctors. It was in vain that Villemin proved the identity of all these lesions, inoculation of the rabbit or the guinea pig always giving the same results, whatever the inoculated product, whether sputum, tuberculous nodules or caseous lung. The opposition only ceased on the day when Robert Koch showed that all these lesions, whatever their microscopic appearance or histologic structure, were due to one, always identical, microbe. Although tuberculosis can be transmitted to all the domestic animals (*our meat supply*), it does not by any means under natural conditions cause equal ravages in each species. Cattle come first among its victims (*the milch cows of our dairies*), the proportion attacked varying according to the locality, the percentage being from ten to twenty of the whole. Horses may be infected under the ordinary conditions of their keeping, and in the horse the disease appears to run a more rapid course and becomes generalized with greater ease than in the cow. Among the smaller animals the sheep and goat are rather refractory to it, while tuberculosis of the pig ranks next to cattle in frequency and is usually generalized in all the organs. The domestic carnivora do not show a great susceptibility to tuberculosis, the exception being intravenous inoculation. However, dogs become tuberculous owing to contact with phthisic people. Kittens, too, are *easily infected by the ingestion of tuberculous material, particularly milk*, as are calves and chickens; *why not babies?* Among the birds of the poultry yard, fowl, pigeons, ducks, turkeys, etc., the disease is very common, and often assumes an epidemic character. The rabbit and the guinea pig are very rarely tuberculous under natural conditions, but they are, especially the guinea pig, excellent reagents for the disease. In them it runs a much more rapid course than in the larger species of animals. This allows many experiments to be completed in a short time, and explains the considerable progress that has lately been made in the study of tuberculosis. The domestic animals of our countries are not the only ones attacked by tuberculosis. It has been found in the camel both in Egypt and in the Kirgheez Steppes. Monkeys kept in the different zoologic gardens die of tuberculosis almost to a certainty. Giraffes, antelopes, llamas, gazelles, zebus, etc., in zoologic collections are also decimated by this disease. Also we have authentic records of tuberculosis in the lion, the tiger, the jaguar, the panther, the fox, the jackal, the tapir, the zebra, etc. Since the discovery of tuberculosis in fish by Dubard our views concerning this most interesting destructive disease have again become decidedly enlarged. We were aware that the bacillus of mammalian tuberculosis requires for its multiplication a temperature between 86 deg. and 104 deg. F., and we concluded from this fact that the germ was an obligatory parasite, unable to multiply outside of the animal body except under special conditions furnished in the laboratory. In the study of avian tuberculosis it was learned that the germ had undergone a most remarkable physiologic change, it now propagated all the way from 77 deg. to 113 deg. F. That now instead of being confined to a radius of 18 deg. F. it was able to multiply within a range of temperature of 36 deg. F. This is both wonderful and alarming. Does this not make it possible for the bacillus tuberculosis to live and multiply in nature as a saprophyte? Dubard's dictionary of tuberculosis in the carp, the bacillus which is able to grow from 50 deg. to 98.6 deg. F., establishes the fact that the bacillus can live as a saprophyte without difficulty if it finds a proper food supply. We have dwelt at some length on tuberculosis, and have endeavored to show its universality, no climate or animal, high or low, being immune to it. Again its stupendous fertility—propagating not only within the animal economy, having a wonderful range of temperature, but living as well without the body. Does this not place tuberculosis, its prevention and its final extirpation, as the greater problem confronting modern sanitation? Tuberculosis is not hereditary. I have made *over one hundred thousand* post mortem examinations of calves up to their year old form and have never seen *one case* of the disease among this number. It must be acquired and from without. Numerous cases are on record where tuberculosis has been transmitted to the offspring of perfectly healthy parents through the medium of milk from tuberculous cows and it *is not necessary that these cows should have diseased udders to convey the infection.* There are times, if not all the time, that the blood of the individual affected with tuberculosis is teeming with the specific poison. The cow has rightly been named "the wet nurse of consumption." Scrofulous females in the human race usually secrete an abundance of milk, because there is an unusual tendency to glandular enlargement and activity. As the mammary is the perfect type of a glandular structure it is stimulated to increased action. A scrofulous cow is usually the largest milker and looked upon by the laity as healthy because of the large milk supply. Does not a tuberculous milk supply account for the large amount of intestinal disorders in children, especially in our large cities? The blood as well as the milk is infectious, therefore the flesh of tuberculous animals should be rejected, as we are not sure that in the ordinary process of cooking the bacillus is destroyed. To sum up the whole matter, will any scientific man argue that an imperfect diseased food supply is not a principal avenue of its entrance ?

This same line of proof and argument might be used in discussing the sanitary shame of American cities, typhoid fever, bad food supply, bad water supply.

Let us now turn from the arch demons of civilization and glance hurriedly at other parasitic diseases, among which we mention notably, trichinosis, with which the whole medical world is familiar, but which is so often overlooked. I have before me a report that a family of eight and two neighbors were made severely ill with trichinosis by eating infected pork. One of the number has died and two others are fatally ill.

Next the tænia echinococcus, the progenitor of the hydatid disease in man, is at present engaging considerable attention from the frequency of its occurrence. Cystercerci are the agents responsible for the tænia solium in man.

Distomiasis is directly communicable to man through his food supply. Each family of parasites might so be traced until they finally found lodgment in the human body, and in each instance the bearer of them would be found to be food, liquid or solid.

Outside of these diseases mentioned another evil confronts us. We refer to decomposition with its attending chain of tyrotoxicon and ptomain poisonings. This is an exhaustive subject, but an interesting one, where food is under discussion. That there is great danger from poisoning from alkaloid substances found in meat from its decomposition can not be too strongly urged. That heat, while it may destroy parasites, does not affect ptomains is sufficient argument to warrant the condemnation of decomposed food and of animals suffering though from only a slight fever for human consumption. This paper, like the subject of ptomains, could be considerably lengthened and then be but half told. We think, however, enough has been written to answer the question considered as a subject and say: *A good food inspection is absolutely essential to health.*

REGULATIONS FOR LAY NURSES, TO PREVENT THE SPREAD OF CONTAGIOUS DISEASES AND TO PREVENT QUARANTINES: YELLOW FEVER, CHOLERA, PLAGUE, SMALL-POX, DIPHTHERIA, TYPHOID FEVER, SCARLET FEVER, MEASLES.

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GENERAL REMARKS.

1. The prevention of the spread of contagious diseases is simple, easy and cheap. It only requires vigilance and care.

2. Success depends upon destroying the germs emanating from the patient's excretions and located in the clothing, bedding, bedpan, etc., before they turn to dust, which dust will infect the air of the room and the whole house. *Unless the air of the room is infected there is no risk of contagion.*

3. The room is the true battlefield; the fight must be made and won in it.

4. It is generally admitted that the patient does not begin to infect his clothing, bedding, etc., before sixty hours, but it is best to begin the disinfection as early as possible.

5. No detail, ever so small, must be overlooked.

6. It is by following these regulations strictly that during the epidemic of 1897, in the City of New Orleans, the inmates of the Isolation Yellow Fever Hospital, Touro Infirmary and Hotel Dieu, were not affected by the fever, although few were immune. When cases of fever occur under these circumstances they are exceptional and are due to some disregard of some regulation.

7. A professional trained nurse is usually the best attendant, but a willing, intelligent and active person in good health can efficiently do this work.

8. The nurse should be provided with a copy of these regulations, should study them, and understand and apply them in spirit and letter.

REGULATIONS CONCERNING THE INMATES OF THE HOUSE.

9. The inmates of the house must change their clothing for non-infected clothing.

10. They must be kept under observation until the period of incubation, five full days, is past, so that if one sickens it may be immediately known and he may be taken charge of.

11. People from the outside who have been exposed in the

presumably infected house are to be considered as inmates, and must also change their clothing for non-infected clothing.

12. Include among the inmates of the house the laundress who washes the clothes of the family. Secure these clothes and disinfect them, and also the other clothes with which they may have been mixed.

13. Do the same with the milkman and the baker.

14. The inmates who must go in and out must remove their clothes when they come in, and leave their clothes in a room remote from the sick room.

15. Expose these clothes to the air and sun as much as possible, all the time, until needed to go out the next day.

16. If needs be, provide them with cheap clothes to wear in the house while the street clothes are being aired and sunned, or vice versa.

17. Be particularly careful that no clothes, no bedding, nothing leaves the room, to be used or not in another room, unless it has been thoroughly disinfected.

18. There can be no such thing as a partial disinfection.

19. One infected handkerchief, towel, toy or other article sent out of the sick room without being disinfected may scatter the infection.

20. It is unsafe to remove articles which have remained in the room sixty hours after the disease has manifested itself.

21. A mild case may cause a malignant case in another.

Articles Necessary for the Management of the Case.

22. ARTICLES TO BE PROCURED FROM A DRUG STORE.

(Copy the following that is in italics and send to a drug store to have put up. Make no mistake in copying.)

23. *1 Nail brush, soft, cheap.*

24. *1 nail scraper.*

25. *2 cakes carbolic acid soap.*

26. *20 pounds of roll sulphur.*

27. *Disinfecting fluid: Water, one quart; bichloride of mercury, 8 ounces;*

28. *Indigo carmin, ½ drachm;*

29. *Chlorate of ammonia, 4 ounces; muriatic acid, 2 ounces.*

30. *The indigo is to give it a warning color so that it will not be mistaken for water, but it is not essential.*

31. *The fluid must be clear, with no deposit after standing.*

32. *One tablespoonful of this fluid to one gallon of water makes a one to one thousand disinfecting fluid.*

33. *Two and a half tablespoonful to a pail of water makes also a one to one thousand disinfecting solution.*

(Signed) Edmond Souchon, M. D.,
President La. State Board of Health.

34. A wooden pail or grocery bucket contains about 2½ gallons of water.

35. In measuring, use a wooden or glass spoon, as the disinfecting fluid attacks metals.

36. It will be more convenient to take a small black coffee cup in which will be poured two and a half tablespoonful of water and note how much of the cup that fills, then use the cup as a measure. Tie a string to the cup so as to mark it, and do not use it for any other purpose.

37. ARTICLES TO BE PROCURED FROM A GROCERY STORE.

38. 10 pounds soft soap.
39. 1 scrubbing brush, for floor.
40. 1 wooden tub, about 24 inches in diameter and 10 or 12 inches deep.
41. 2 pails; one pail contains two and a half gallons of water.
42. 2 mops, one for dirty soilings and one for light soilings.

43. ARTICLES TO BE PROCURED FROM SPECIAL STORES.

44. 1 mattress, new.
45. 1 extra mosquito bar, bobinet.
46. 4 pairs of sheets, white cotton.
47. 6 pillow cases, white cotton.
48. 2 pillows, moss, white cotton.
49. 2 coverlets, white cotton.
50. 1 light woolen blanket.
51. 24 towels, white, soft.
52. 6 sheets for patient, white cotton, smooth.
53. 6 drawers, white cotton, soft.
54. 12 handkerchiefs, white, soft.
55. 2 pieces of white oil cloth, 6 feet x 8 feet, to protect mattress and tucked or sewed around.

56. ARTICLES TO BE PROCURED FROM A CROCKERY STORE.

57. 1 large cylindric kettle to boil plates, spoons, glasses, etc., also to boil water, 1 foot in diameter, 8 inches deep.
58. 1 bedpan.
59. 1 urinal.
60. 2 washbowls and pitchers.

TO BE PROCURED FROM A FURNITURE STORE.

61. 2 small tables, 2x3.

62.—REGULATIONS FOR THE SICK ROOM AND DISINFECTION OF PATIENTS' CLOTHES, ETC.

63. The nurse must have at least two changes of under clothing and four changes of over clothes.

64. The nurse must wear no woolen fabrics.

65. Select the most favorable room in the house.

66. Remove from it all unnecessary furniture, rugs and the ornaments.

67. Have it promptly scrubbed and cleaned generally.

68. If the bedding is not clean or has been used for some person's sickness, burn it and use new mattress, bar, sheet, etc.

69. Spread a large piece of oil cloth over the mattress and tuck it all around or pin it, so as to surely well protect the mattress.

70. Give the patient clean bed clothes.

71. Then place the patient in bed.

72. Do not allow any one in the room.

73. One or another member of the family may be admitted into the room at the time.

74. He or she shall remain in the room as little as possible.

75. He or she shall change his or her over clothes daily like the nurse does.

76. The minister may visit daily for ten minutes.

77. Always have ready for use one or two pails of the disinfecting solution prepared by pouring the equivalent of 2½ tablespoonfuls of the disinfecting fluid to a pail of water.

78. Always have ready for use a large wooden tub containing three pails of the solution prepared by pouring the equivalent of 2½ tablespoonfuls of the disinfecting fluid to a pail of water.

79. No heavy woolen article must be used for any purpose; use no quilt, but use coverlet of cotton.

80. Should the weather be cool a light blanket and woolen sack may be used, but will have later to be disinfected with care.

81. The patient's clothing must be changed at least once daily, twice daily is better.

82. The clothing, bedding, etc., must never be shaken. They must be handled gently, with care, so as not to shake the dust from them.

83. Place them at once in the disinfecting solution in the tub.

84. The bedding, sheets, coverlets, pillows must be changed daily.

85. The bar must be changed every second day.

86. Place them at once in the disinfecting solution in the tub.

87. Place also in the tub the handkerchiefs, towels and rags used for cleaning and sponging the patient or for any other purpose.

88. The clothing and bedding will be well soaked in the disinfecting solution in the tub for one minute.

89. Then wring them slightly, enough to prevent dripping.

90. Lay them aside and let them stand wet one hour.

91. Then they may be sent to the wash.

92. The disinfecting solution from the tub will be emptied once daily into the gutters.

93. The tub must then be washed with fresh solution; inside and outside.

94. Then prepare another tub with three pails of the disinfecting solution in it.

95. Clothing and bedding must be changed at once, if soiled by sputum, vomit, urine, feces.

96. Bulky articles (blankets, mattresses, etc.), when partially soiled, must be washed with soap and disinfecting solution for three hours.

97. If extensively soiled they must be burned at once.

98. The water which is used to sponge or wash the patient or to rinse his mouth must be mixed with one quart of the disinfecting solution, and allowed to stand two hours before thrown away.

99. One quart is represented by a large wine bottle or by four tumblerfuls. Measure these quantities in a pitcher, note the amount and use the pitcher for a measure.

100. The sputum must be disinfected with special care. Use no spittoon.

101. Use a cup or plate and keep them half full with the disinfecting solution. Add to the cup or plate the value of a half tablespoonful of the disinfecting fluid from the bottle. Let it stand five hours before throwing in the closet or the gutters. It is much better to use rags and burn them.

102. The urine must be mixed with one quart of the disinfecting solution from the pail. Add in the vessel the value of one tablespoonful of the disinfecting fluid from the bottle. It must stand five hours before being emptied into the closet. Stir up occasionally, specially before emptying.

103. The chamber and urinal must be washed with the disinfecting solution from the pail inside and outside.

104. It shall be kept at all times filled with the disinfecting solution.

105. The feces must be mixed with two quarts of the disinfecting solution if very liquid. Add in the bedpan the equivalent of the two tablespoonfuls of the disinfecting fluid from the bottle.

106. When dry and hard they must be broken up with sticks and burned.

107. But soft or solid feces had better be burned. Build a small wood or charcoal fire in the yard, and when in full blaze, throw the feces on it in small quantities at a time.

108. The chamber or bedpan must be treated as directed above.

109. All vomited matter must be mixed with one quart of the disinfecting solution. Add in the vessel two tablespoonfuls of the disinfecting fluid from the bottle; allow it to stand five hours before being emptied.

110. Clean the vessel inside and outside with the disinfecting solution.

111. Keep it filled with the disinfecting solution.

112. The water used in washing anything about the room must be mixed with one or two quarts of the disinfecting solution and allowed to stand one hour before emptying.

113. The glass, plate and spoons used about the room must be disinfected every time they are used, by boiling for ten minutes.

114. The room must not be swept, but sprinkled and mopped with the disinfecting solution from the pail.

115. The mops must be wrung out in the disinfecting solution from the pail.

116. The water from the washings and moppings must be mixed with one quart or two of the disinfecting solution and allowed to stand one hour before emptying into the gutters.

117. The nurse's clothing must be also changed twice daily; all her clothes must be placed also in the solution in the tub.

118. The nurse must keep her hands aseptic all the time by washing them in the solution from the pail every time she touches the patient or soiled things; then she must rinse them in clear water to prevent the mercury from making the nails sore.

119. The nurse or anyone else must never drink nor eat in the room, nor use any plate, glass, spoon, fork, knife, etc., which have been used by the patient.

120. The nurse's hands should be frequently washed with carbolic soap and plain water.

121.—Disinfection of the Patient After Recovery.

122. *The Disinfection of the patient after recovery* must be done by washing him all over with a solution (tepid) of the disinfecting solution from the pail. Wash him as when his body is sponged; follow by a wash with alcohol, or by bay rum or cologne water.

123. The hair must be thoroughly washed with the disinfecting solution, then with alcohol or cologne water and then thoroughly dried.

124.—Preparation of the Corpse for Burial—Funeral.

125. *The corpse for burial* shall be wrapped up in a sheet, saturated with a solution of bichloride of mercury from the pail. Add to the solution in the pail four tablespoonfuls of the disinfecting liquid from the bottle.

126. This should be done as simply and quickly as possible.

127. No funeral service should be held in the house, but at the cemetery.

128. One or two members only of the family may accompany the remains to the cemetery.

129. No friends or acquaintances shall be allowed to do so.

130. The draperies from the hearse shall be removed.

131. After the removal of the body sulphur shall be burned in the room and house for twelve hours.

132.—DISINFECTION OF THE ROOM IN WHICH THE PATIENT HAS BEEN SICK.

133. Be particularly certain that no bedding, no clothes, etc., are removed from the room unless they have been thoroughly disinfected.

134. Toys, books, etc., used by the patient must be burned.

135. *Sulphur shall be burned in the sick room and adjoining rooms.*

136. All drawers and doors of furniture should be opened, and all fabrics that do not admit of other treatment should be opened out as much as possible.

137. Spread the clothes.

138. Stretch ropes across the room and spread the clothes on them. Anything folded thick will not be reached by the disinfection.

139. The room should be closed and made as tight as possible by stopping all openings in floor, walls, chimneys, and cracks near windows and doors.

140. Be careful and close the opening of the fireplace by tacking a folded sheet over it as tightly as possible.

141. Crevices can be closed by pasting strips of paper (old newspaper) over them with a paste made of flour.

142. After the room has been thus prepared, roll sulphur should be burned in the room, three pounds to 1000 cubic feet of air space, or about nine pounds to an ordinary room.

143. The sulphur should be placed in an iron pot, and this placed on bricks in a tub with about one inch of water in the bottom.

144. This precaution is taken to guard against accidents, as the sulphur is liable to boil over and set fire to the house.

145. The sulphur is easily ignited by sprinkling alcohol over it, and then lighting it, or by placing kindling pine in the pot crosswise and piling the sulphur on the lighted pine.

146. The apartment should be kept closed fifteen hours, and then opened and well ventilated.

147. After this ventilation the walls, floors, ceiling, and furniture should be well sprinkled with mercuric chloride solution from the pail and afterward washed down with warm water.

148. When disinfection is not started within two days of the time the disease began, the disinfection of the room must be more thorough.

149. Mattresses, quilts, heavy woolen articles, etc., must be burned.

150. Carpets should be saturated with the disinfecting solution, dried, then swept, and again saturated.

153. After the apartment and contents have been thoroughly fumigated, all the stuffed furniture should be dismantled and the stuffed fabrics together with the mattresses should be covered with sheets, taken into the yard and burned.

154. Carpets should be saturated with the disinfecting solution, dried, then swept and again saturated.

155. Disinfect with sulphur the other rooms of the house.

SPECIAL REMARKS.

156. In *cholera* it is specially through the mouth from the vomiting and evacuations that the disease is communicated. Therefore no one should drink or eat, etc., in the room.

157. In *typhoid fever* also.

158. In *plague* also. Besides, in plague, all little sores on the nurse's finger, etc., should be covered with plaster or collodion.

159. All the rats, mice and vermin about the premises should be killed and burned.

160. In *diphtheria* the germs are contained specially in the secretions from the mouth and nose. Therefore no one should eat or drink in the room.

161. In *small-pox, scarlet fever* and *measles* smear the patient's body with white vaselin as soon as the peeling is about to begin, so as to prevent its drying and turning to dust before it is destroyed by disinfection.

162. As long as the least peeling continues the patient must not de discharged and the disinfection of excretions, clothing and bedding must be kept up.

163. In *small-pox* the scabs should be gathered with care and burned.

164. Search the scalp of patients for scabs, remove them and disinfect the spot.

165. In cases of *scarlet fever* and *measles*, also, the peelings must be gathered with care and burned.

166. Patients recovering from a contagious disease may communicate the disease as late as fifteen days after recovery. Therefore continue all the disinfection of excretions, clothes, bedding for fifteen days after recovery.

Clinical Lectures.

Specially Reported for the Journal from the Philadelphia Clinics.

I.

A TYPICAL CASE FOR THE USE OF DIGITALIS.

By Prof. ARTHUR V. MEIGS, M. D.

The patient is a woman, 54 years of age, English by nationality. The illness for which she was admitted to the hospital began about seven weeks ago, after an exposure to cold, with chills, pains in the lumbar region, and a general feeling of ill health. She remained in this condition for about two weeks, when she was obliged to go to bed. At this time she complained of shortness of breath, which was greatly intensified by any slight exertion. She also had considerable cardiac palpitation, which was sometimes of considerable duration. For the past year she has had a very free secretion of urine, which is a point of interest in regard to her present condition. The urine was pale in color and large in quantity, but since her last attack it has become diminished in quantity and dark in color.

Her appetite is poor, and she suffers from occasional attacks of nausea; she has tenderness over the abdomen, especially over the region of the stomach. From the beginning of the illness she has been nervous and irritable. She noticed that her feet and legs began to swell four weeks ago, and they are now enormously swollen. She has complained of a cough for the last few weeks, and has some expectoration. Lately there is a marked swelling of the abdomen. Her right leg, as you see, is more swollen than the left. If we can believe what she says, the right leg has always been very much swollen ever since an attack of typhoid fever. There is a crease around the ankle. Now, this is very much the shape of the swelling of elephantiasis. You see the swelling is very great, and there is deep pitting on pressure on both sides. I was unable to obtain any signs of fluid in her abdomen. It is very large and flabby, and she has some erythema in the creases of her abdomen. If there were fluid it would certainly be much more tense than it is.

I certainly do find, however, some enlargement of the liver. There is a little soreness over the enlarged liver, which I think is due to a condition of congestion.

Now, this edema of the lower extremities excites a suspicion of cardiac disease. Yet none of those who have examined the heart can detect any murmur. The heart is very irregular. The breathing is accompanied by some few ronchi. There is no albumin in the urine; there is enlargement of the liver.

The question comes to me simply, "Is this a case of contraction of the kidney, or of heart disease where there is not at present any murmur?"

Now I think the whole trouble is due to her heart; in fact, I am quite positive of it. And I think this on account of the enlargement of her liver. It was a point laid down by Fagge, in his book which is now considered rather old-fashioned. He spoke of the difficulty, in many cases of dropsy with an affection of the heart, of determining whether the cardiac affection were primary or coincident with the renal condition. If the liver is enlarged, he said the trouble is due to the heart. Renal disease has no effect on the liver while cardiac disease has. Now a murmur is absent in the case; if one has been present it has disappeared. I think it likely that with a return of greater strength to the organ the murmur may reappear. In the last stages it frequently disappears. In the first stages of initial stenosis we may have a murmur and two sounds; later we have the murmur and one sound, while in the third stage the murmur itself disappears, because the right auriculo-ventricular valves give away. This is often seen in initial stenosis. Then as improvement takes place, the murmur returns. I should not be surprised if, with a suitable use of digitalis, for there is no other drug comparable in cases of this sort, no one would take strophanthus or convallaria, or adonidin if he could possibly get digitalis; I should not be surprised, I say, if when the heart is strengthened by the use of digitalis, the murmur should return.

Now, as a preparation of digitalis she has been taking the tincture, which many regard as the best; but I must confess I prefer the powdered leaves to any other. Each man, you know, must have his own hobby in the use of digitalis. If an infusion is made from the fluid extract, as it so frequently is, we will not get the results that we wish.

If in using this drug we do not get the results that we wish, there are one or two reasons. First, the drug may be absolutely worthless. When you use the powdered leaves you certainly get the drug itself, and the whole of it. I have seen such wonderful results from the use of the powdered leaves that I can not help preferring it. A favorite prescription of mine is one grain of the powdered digitalis, two grains of nitrate of potassium; then if the patient has a cough, one or two grains of Dover's powders. Now, to go back to the failure to obtain results, another reason is because there is nothing for it to act upon. If the heart is fatty or if the muscle is gone, you can not expect digitalis to act. There comes a time when the muscle fibers are so degenerated that it can have no effect. But this woman is not in that condition.

We will continue the tincture unless we find it unsatisfactory. It was a rule of Balfour, I think, to give fifteen drops of the tincture every three hours for the first twenty-four hours. Now that is pretty heavy dosage. After that the quantity was reduced. The idea was to get the heart immediately under the influence of strong doses.

The bowels should be kept freely moved in cases like this, with a solution of magnesium sulphate. Her dyspnea is entirely due to a bronchial catarrh.

Now this edema is a sign that is very interesting. We rarely see it in aortic disease. It is quite the exception. In mitral disease it appears at a comparatively early stage, and especially in those who are accustomed to work standing on their feet. It appears first in the evening and disappears by the next morning, then gradually it stays longer and longer until finally it is present all the time.

You may recollect that this patient's temper was said to be irritable. You will notice that in many cases of heart disease I am sure. It is said by those who have had more opportunity for studying the question that the mental disturbance in mitral affection tends to melancholy while in aortic disease it is toward mania. At any rate, I have aften noticed a change in patients with aortic disease which is certainly very different from the hopeful mental condition of one in advanced phthisis.

I think there is not much benefit to be derived from strophanthus as a substitute for digitalis in organic heart disease; there may be more in functional disease. Spartein is a good substance to intermit with the use of digitalis. Adonidin may be given in doses of one-twelfth grain or spartein in doses of one-fourth grain. Perhaps above all the other drugs of this class is caffein. I would give four or five grains three or four times a day if I wished to obtain its full diuretic and heart tonic effect.

I want to present this patient to you next week quite improved. There is, of course, the accident of embolism always possible in these cases, and that no man can foresee.

This is the kind of case most favorably influenced by digitalis; that is an irregular heart in a mitral disorder, whether obstructive or regurgitant, rather than aortic disorder.

II.

1. A CASE OF JACKSONIAN EPILEPSY SPECIFIC IN TYPE—2. TRAUMATIC HERNIA—3. CARCINOMA OF BREAST.

BY PROF. W. W. KEEN, M. D.

1.—The case now under consideration is one which Dr. J. C. Da Costa brought before his clinic some ten days ago. The man had been picked up in the street almost unconscious and was brought to the hospital. The only lesion found was a small scalp wound of the left side just above the eye. For two days the patient lay in a dreamy, half-conscious state and the diagnosis of cerebral concussion was made. Three days after his admission convulsions of a peculiar sort began. A twitching would begin in the face on the left side, and after a time this would extend to the arm and leg of the same side. These became more violent and increased in number until the man was almost in the condition of *status epilepticus*. But during all this time he was conscious.

Here, then, was a man who had suffered from concussion arising from a blow or fall on the left side of the head and afterward developed Jacksonian epilepsy on the same side. As it is exceedingly rare for epilepsy to occur on the same side, it was thought there must be two independent conditions present, a blow on the left side causing concussion and an injury of the right side giving rise to the focal epilepsy. The man's condition was getting worse and his left side becoming paretic. It was a question as to whether trephining should be done and the face center removed.

The man denied previous specific history, but it was decided to put him on treatment before operating. Accordingly potassium iodide in rapidly increasing doses was given, with the most pronounced results. The attack lessened and finally ceased entirely in a few days, the man now having had no attack for over a week. The case then was one of syphilitic epilepsy in which the use of potassium iodide in heroic doses saved the man an operation. The iodide was pushed rapidly, as it should always be in these cases, the man getting as much as 180 grains in twenty-four hours.

2.—A CASE OF TRAUMATIC HERNIA.—Our next case is a boy of sixteen, who fell a short distance some eight years ago, and struck with some force on his right groin. One week afterward a lump appeared in the groin and has since remained. Here then was a distinct case of traumatic hernia. About ten days ago the lump became larger than usual, gave great pain and could not be reduced. Strangulation is much more apt to follow hernia of this kind than where the hernia develops gradually and stretches the tissues of the ring slowly.

The boy was brought to the hospital where the hernia was finally reduced by the resident surgeon in charge. I have purposely waited until now for operating that the mechanic injuries may subside before the radical cure is attempted. There is a small swelling still in the upper part of the scrotum, where the scrotum and thigh join, which can not be reduced. This is probably a hydrocele of the cord and will be opened at the time of the operation.

I shall do the Bassini operation, as this is *the* operation for the radical cure of hernia. There are almost numberless methods, but this has stood the test of time far better than any other. As the patient is prepared the hydrocele is not found except a slight hardness at the point where the swelling was noticed yesterday. This, as it is opened, is found to be the end of the hernial sac.

As to the dressing in these cases, I do not think it necessary to use plaster of Paris as some operators do. A long piece of gauze is placed longitudinally over the wound, then this is covered by other pieces at right angles. Then a large piece long enough to cover the previous ones and reaching well beneath the thighs is taken and a hole made through which the penis passes. In a child a piece of rubber dam is applied in order to protect the dressing from the urine. The bandage is then applied, always using a spica of the groin.

3.—Carcinoma of Breast.—The patient is a woman of forty-four, who first noticed a lump in the right breast two years ago. No pain was felt until within six months. There are two or three points about this tumor to which attention may be called: (1). The lump is in the extreme outer part of the breast and toward the upper quadrant. It is freely movable and the axillary glands are slightly involved. (2). The nipple is not retracted, simply because the carcinoma is situated on the periphery of the breast. (3). No pain was felt for over eighteen months after the tumor was noticed, when it became sharp and lancinating. The presence or absence of pain has nothing to do with the presence of cancer, and this is why so many of them are seen late, as pain is generally the cause of the patient seeking medical advice. (4). All the gland but the very small part occupied by the tumor feels normal, but it will all be removed. The glands of the axilla as well as the pectoral muscles will also be removed with the breast.

Our experience up to the present time leads us to believe that no case of carcinoma is safe without the removal of both the greater and lesser pectorals. It would be well to leave them, although their removal does not add to the gravity of the operation to any extent, if it was thought safe to do so.

Perhaps future results may change this opinion as to the necessity of their removal, but at the present time it is thought necessary. I am very much pleased with the lately introduced incision over the arm instead of directly into the axilla. The axilla can be reached handily by working down from this incision, and the cicatrix does not interfere with the raising of the arm as does the one extending into the axilla.

III.

1. AN INTERESTING CASE OF ENTERIC FEVER WITH REMARKS ON THE DIAGNOSIS AND TREATMENT OF PERITONITIS. 2. ADDISON'S DISEASE.

By Prof. JAMES C. WILSON, M. D.

1.—The man from whom the specimens before us were taken was admitted to the hospital October 26 and died during the night of November 2. He strolled into the outpatient department saying he had been feeling badly for four weeks. His temperature was 100.4 deg. at that time and after his admission ranged between 103 deg. and normal. An examination of the blood was made, but the Widal test gave no positive reaction.

There were no rose spots; the spleen was only moderately enlarged; there was evidence of pulmonary tuberculosis. A provisional diagnosis of enteric fever was made, but cold bathing was not begun. The fluctuations in temperature suggested those of miliary tuberculosis. Later a second Widal test was made and this time was positive. Shortly after signs of perforative peritonitis appeared and the man died as stated. Post mortem shows the perforation to be about four inches from the ileo-cecal valve. The appendix shows a state of chronic catarrhal appendicitis. The spleen is not greatly enlarged, but perhaps more so than was thought because of its shape.

The abdomen was not tympanitic but rather flat, the walls being of a board-like hardness. There are two clinical stages of acute peritonitis arising from any cause, but especially marked in those resulting from perforation. In the first there may or may not be pain, generally there is some pain, and the abdomen is slightly distended, with the marked board-like hardness referred to. This is entirely different from the balloon-like distension of the later stage. It is in this first stage that the chances for surgical relief exist, as after the ballooning appears operation is practically useless. The surgeon who saw this considered it unfavorable for operation, and perhaps from the condition of the gut it would have been, the gut being covered with a thick exudate.

But it is my policy to recommend surgical interference in all cases seen sufficiently early. It is the only chance, and the patient should be given the benefit of it. A considerable percentage, perhaps nearly one-fifth of cases operated upon, have recovered. The number is limited, it is true, but the operative cases reported are also limited, and the successful cases are enough in number to justify the method of treatment.

The condition is analogous to pistol wounds of the intestine, of which from one to twelve have been repaired and the patient has recovered. No surgeon hesitates to operate on such a case, but there is a hesitancy as regards perforation in enteric fever. Of course the condition of the patient and of the intestine are less favorable in the latter cases, and the chances are less favorable in cases of fever than in those of acute traumatism. But the fact remains that there are practically only two terminations of the condition in enteric fever—death or a successful operation; therefore, if success attends only a moiety of the cases, if even only one of many operations is successful, the patient should have the benefit of this chance, and the surgeon should operate in every case seen early enough.

2.—ADDISON'S DISEASE.—The direct diagnosis of Addison's disease is generally easy. The disease, however, is often diagnosticated when not present because of pigmentation which may be present. This may be present in so many affections that its presence alone does not justify the diagnosis of Addison's disease. I do not support the use of tuberculin as a diagnostic agent. Although tuberculosis of the suprarenal capsules is the lesion in the great majority of cases, the value of the test is not of sufficient degree to justify the lighting up of the tubercular process by this means.

The treatment may be divided into the general sympathetic and the use of suprarenal extract. Under the first head comes rest in bed, avoidance of exposure to cold and of mental shock and worry. The diet should be nourishing and varied constantly with the view of tempting the individual to eat. If constipation be present it must be handled with great care lest an obstinate and exhausting diarrhea be started. Vomiting may be controlled by cerium oxalate, Lugol's solution, iced champagne in sips, etc. Alcohol and strychnia may be useful as stimulants.

Some cases are benefited by the administration of suprarenal extract and others are not. This treatment should be tried in all cases. Fifteen grain tabloids may be given, one three times a day at first, the dose being gradually but boldly increased. As much as two drachms a day have been given in certain cases. The results do not equal those from the use of thyroid extract in myxedema but are sufficient to warrant its use.

IV.

1. THE TREATMENT OF A SIMPLE CASE OF NAUSEA AND VOMITING IN PREGNANCY. 2. CARE OF THE BREASTS AFTER MISCARRIAGE.

By E. P. DAVIS, M. D.

1.—The exact cause of the nausea and vomiting of this patient is not very plain. She states that the movements of the child are very active at times and that these are followed by attacks of vomiting. She also has some restlessness and insomnia at night. The case has been one of the simplest sort with no particular assignable cause and the treatment has been one which is adapted to such cases.

A laxative should be given to such patients. Different ones may be used, but if the tongue is heavily coated small doses of calomel, followed by a saline, are preferable. A saline should be given every day if it acts well; if not a teaspoonful of cascara cordial night and morning will keep the bowels active. Deficient elimination is quite often the cause of vomiting in pregnant patients, and this must be carefully looked after.

As a tonic, one drop of Fowler's solution and one-half drachm compound tincture of gentian should be given before each meal. For a sedative, ammonium bromide is used. Potassium bromide should be avoided in these cases.

A very important point in the management of these cases to prevent their developing into a more serious stage is accurate observation of the patient. Take no statement of theirs as to the amount of sleep or the quantity of material vomited. The personal equation has so much to do in these instances that one can hardly be sure of the exact state of affairs present. Some are frightened in regard to the vomiting and state that the whole meal has been ejected when perhaps only a few mouthfuls of mucus has been the real quantity. Others make light of such occurrences and are really starving because the food is not retained. Get them under observation of yourself or nurse if possible, or see them often and note any changes that may occur.

If this case does not do well under the treatment above outlined, which, however, she seems to be doing at present, she will be put at absolute rest and fed on predigested food at regular intervals. If this does not suffice labor will be brought on at once, as she is now very nearly at term.

2.—Care of the Breasts.—A kind of muslin should be accurately applied to the body in order to support the breasts. This should be kept in place by straps passing over the shoulders and crossed behind if necessary. The binder should be applied in such a way and of sufficient tightness to gently compress the breasts and bring them as near as possible to the middle line. Over each nipple is placed a bit of sterile lint and each breast covered by a pad of sterile gauze before the binder is applied. In many cases this is all that will be necessary.

In other instances where the breasts become congested with milk, gentle massage or pressure of the ducts from the periphery to the nipple and the application of the breast pump at times may be necessary. This can be done without giving the patient much pain, but should not be resorted to unless the accumulation of milk is of considerable quantity.

In a small proportion of cases the application of an ice-bag or coil is advisable. Great care should be taken that this application be made perfectly dry. The principal points in managing these cases is the proper application of the bandage and the keeping of the nipples perfectly sterile. The great majority of cases will do well with this simple management, a certain proportion will need the judicious application of the breast pump, and yet a smaller number may require the ice-bag in addition to the other measures.

V.

1. TREATMENT OF AN IMPROPERLY FED CHILD. 2. BRONCHO-PNEUMONIA.

By E. E. GRAHAM, M. D.

1.—The child I now present is ten months old, born natural, and fed at the breast until four weeks ago. Children should be weaned at one year of age, unless this time comes in very warm weather, when it may be lengthened somewhat. It is better to begin at about the eleventh month as a rule.

Since being weaned this child has lost flesh and has suffered from bowel trouble, at times having seven or eight movements daily. They are now three or four and black in color. Vomiting has also been a symptom. The child has been fed on crackers, bread and butter, vegetables, etc., with some milk.

We have here a good illustration of how not to feed a baby. Thousands of such children die yearly, as this one would soon do under the present conditions.

In treating this child I would leave off milk entirely for four or five days, and pay attention to getting the alimentary tract thoroughly cleaned. Calomel should be given in the dose of one-tenth grain every two hours until six doses have been taken. Every two hours the child should be fed a weak mutton broth or properly prepared beef tea, four ounces at a feed. Between the times of feeding an abundance of sterile water should be given. After three or four days milk may be given. The amount of fat and proteids should be one-half the normal amount at first. The sugar need not be decreased in this proportion or at all. Beginning with this reduced amount, the milk may gradually be brought up to its full strength.

The large bowel should be irrigated daily for a time with normal salt solution. The child should be in a horizontal position on a prepared couch, or in its bath tub. A number twelve male catheter, flexible, and a fountain syringe held two or three feet above the child, are to be used. In this way, if care is taken, a pint or more of fluid can be introduced before it is expelled. A gallon of the solution may be used at each time. The main seat of inflammation in these cases is at the ileo-cecal valve. Internally, subnitrate of bismuth may be given if the looseness continues.

2.—BRONCHO-PNEUMONIA.—This child is also ten months old, and is now convalescing from an attack of broncho-pneumonia. This is the most troublesome form of the disease in many cases. Lobar pneumonia is an ugly looking disease in children at times, but the great majority get well. In this type the disease runs an irregular course, and as it is often a secondary pneumonia, complicating a disease which has already weakened the patient, it is a dangerous affection. In this case the child was practically well before the attack, and the prognosis was much more favorable.

Flannel was applied to the chest and the position of the child was changed every two hours in order to avoid hypostatic congestion. The child was fed every two hours with milk which was adapted to its age and condition.

Medication consisted in the use of the following:

℞ Strych. sulph.	gr. $\frac{1}{15}$.
Amm. chloridi	gr. xlviii.
Syr. senegae	ʒ ii.
Syr. tolu	℥ i.
Aquae dest., q. s	℥ iii.

M. Sig. Teaspoonful every two or three hours.

Improvement has been rapid, and there is practically no hypostatic congestion present. The above prescription will now be stopped and fifteen drops of the peptomanganate of iron given with the milk three times a day.

CERVELLO'S METHOD IN TREATING CONSUMPTION.—In the Hüfeland Society of Berlin, Germany, January 25, 1900, Liebreich spoke on Cervello's Method of Consumption Treatment. After having given the method of Brehmer due consideration, he stated that said method was able to raise the vital force and power of resistance of the cell against the tubercle bacillus and its toxins, and that he, Dettweiler and others have obtained good results by its application, but it is insufficient, for while incipient cases can be cured, more advanced cases only may here and there find a healing process. Now the physician can not be contented with such results and will be compelled to return to the pharmacodynamic treatment. Cervello, who possesses the most magnificent sanatorium of the world in the immediate vicinity of Palermo, has done this. He brings a preparation of formalin-iodide in the sickroom and heats it by means of an alcohol lamp. Thereby the formalin vapors become free and Cervello allows the patients to inhale them for hours. No irritation of the membrane of the respiratory passages occurs and Cervello declares that he obtains splendid results by this method.—*Deutsche Medizinal Zeitung*, No. 13, 1900.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE NEW ORLEANS MILK SUPPLY.

It is a good thing to find the New Orleans *Times-Democrat* and *Picayune* agitating the question of the purity of the milk supply of this city. These two dailies have grown somewhat controversial, in itself an argument for the necessity of agitation and investigation.

The City Board of Health has for quite a long time endeavored to secure pure milk, and its officers have used all means to have the dairies observe hygienic practices in preparing the milk for consumption by the public. More than this, the chemist of the Board of Health has repeatedly proven the practice among dairymen of dispensing milk adulterated with various substances, chemical and otherwise.

This line of procedure on the part of the health authorities has resulted in much good, for the punishment under the law of a long series of offenders has made the intending malefactors more careful at least, and it has besides created a public apprehension which has brought about a more systematic tendency to cleanliness and purity of milk supplied by those vendors who wish to be honest.

The present agitation aims at something more radical and at a phase of the milk supply elsewhere considered vital, viz., the transmission of tuberculosis through the milk supply. Dr. Chas. Heitzman, associated with the Board of Health as inspector of meat, etc., and a prominent local veterinarian, provoked newspaper criticism by suggesting the usual prevalence of tuberculosis in cattle and the likelihood of this as a source of this disease in the human subject. This is not a new proposition, for in European centers the practice of inspection is most thorough and the remedy radical, the diseased cattle being promptly annihilated.

The State of New York has stringent laws bearing on the same question, and these are enforced by the health authorities. The larger dairy concerns supplying milk to the cities of greater population in the North have their own inspectors of cattle, recognizing that by anticipating trouble they thereby best prevent it.

New Orleans is slow to accept reform and not less so even where health is concerned.

The last few years have seen, however, quite a number of needed health measures, and this question of milk supply is by no means an unimportant one. In a city with the exceptional high mortality from tuberculosis which New Orleans shows, any and every measure should be sought, promulgated and executed, which might prevent or forever cut off an avenue of infection. Controversy continued only provokes discredit of the necessity for a sanitary measure, and we believe that the daily press should set aside opinion and attack the proposition solely from the high plane of the public welfare, and should from that point of view help find the way to solve a question of moment, even if the degree of its importance may be a matter under judgment.

TULANE ALUMNI ASSOCIATION.

A glance at the first publication of the Tulane Alumni Association* shows among the graduates enumerated a list of over five hundred from the Medical Department. The fact that their names appear is evidence of an interest in the welfare of the college which graduated them.

"All roads lead to Rome!"—It is then to be hoped that this organization of medical men may stimulate an active co-operative interest in them for an improved status of the Medical Department of Tulane, in keeping with the pace set by medical education elsewhere.

The East and North have an active alumni system in many of their college institutions; some of these are even governed by their alumni, who elect the trustees, board of governors, corporation or whatever the directing body may be named.

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* A pamphlet giving the Constitution and By-Laws, list of members, etc.

Tulane has not reached that point yet, but with such a healthy showing as the pamphlet of the Alumni Association presents, the day is not far distant when the voices of those who have gone before must be heard.

We have at all times urged organization among the medical men and all kinds of healthy organization. Tulane has sent out a large number of medical men, in this and neighboring States, only a fraction of whom are members of the Tulane Alumni Association. These should fall in line, because this association promises to be a working body and the only one with the operative power to accomplish definite educational ends.

With the assurance of being heard, the file of members can aid medical education in this section, by stimulating the attendance of students at our schools and the increase in classes will necessitate an elevation of the standard, a compliance with the demands of education commensurate with the importance of New Orleans as a center of education, for medicine, and for art, science and philosophy as well.

THE STATE MEDICAL SOCIETY.

Elsewhere in this number will be found a preliminary program of the meeting of the State Society to meet in New Orleans on the 19, 20, and 21, of this month.

The several section chairmen have arranged general subjects for discussion in order that all members so desiring may take part. The indications are favorable for a good attendance, and the JOURNAL hopes that this year may be a record breaker.

The status of a community of professional men is always measurable by their interest in their common work and whether local, urban or State societies are considered, the amount of interest shown at the meeting is a criterion of the men composing it.

Let every member show his loyalty to his State and profession by being present.

THE OUNCE OF PREVENTION.

Since the first troops went to Cuba our local health authorities have, from time to time, called attention to the laxity in quarantine and disinfection methods at Northern ports. The

Soldiers' Home episode last summer, and Col. Waring's death in New York, aside from any other evidences, should be a lesson for the future to those in charge of port sanitation and prevention.

Our own Mississippi quarantine is always on the lookout for suspected vessels, and, more than that, each year special officers are sent from New Orleans and Mobile to Central American ports to see that vessels start this way with clean bills of health.

This year every precaution will be taken to prevent the invasion of New Orleans by yellow fever. With the object of striking at a cardinal point of weakness in the defense of this and all Southern communities, the Louisiana State Board of Health passed, on March 13, the following excellent resolutions petitioning the Louisiana representatives at the National Capitol to expedite the ounce of prevention:

> "Resolved, That this Board respectfully requests the Congressmen of Louisiana to make the most earnest efforts to have enacted by the United States Congress the proper legislation to compel vessels sailing from ports liable to yellow fever and arriving at Northern ports to be subjected to the same regulations as such vessels undergo when they arrive at the Mississippi River Quarantine Station and other Southern ports."

THE CHARITY HOSPITAL ALUMNI ASSOCIATION.

The annual meeting of this association will take place in New Orleans on April 18, 1900, the evening before the meeting of the State Medical Society. This date has been selected in order to facilitate the attendance at both of the members belonging to the two.

The officers are doing all in their power to arouse an interest in this meeting and we trust that the members, the list of whom extends into several states, will respond in large numbers and weld another strong link in the chain of good-fellowship which binds the ex-internes of old "Charity."

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of DR. F. W. PARHAM, assisted by DR. F. LARUE, New Orleans.

IMPROVED INCISIONS FOR ENTERING THE ABDOMINAL CAVITY.—Several articles have recently appeared in the medical journals describing methods of laparotomy, which we believe further experience will show to be valuable additions to our operative resources.

Thus, Weir, in the *Medical News* of February 17, describes a plan which he has carried out systematically for the past year.

"Some two years since, being led to it by the experience obtained since 1894 in the oblique incision for gall-stone surgery, wherein additional room was had by incision of the rectus sheath, drawing the muscle to the median line and then dividing the posterior fascia, I ventured to increase the intermuscular space of McBurney by similarly treating the rectus at this lower level. I was at first hampered by the difficulty of dragging the median edge of the divided fascia of the external oblique sufficiently far inward to expose amply enough the anterior sheath of the rectus muscle. For the past six months the procedure has been simplified and made more desirable by tearing off with the finger tips or with the end of a blunt scissors the already denuded fascia of the external oblique muscle from the sheath of the rectus quite up to the median line, where it is held retracted by an assistant. The anterior sheath of the rectus is now divided transversely in a line continuous with the opening made in the peritoneum by the original muscle separation operation. The outer edge of the rectus muscle is then lifted up with a director or the end of blunt scissors and carried by a retractor also to the median line, or as near as may be desired. On the thin transversalis fascia, with the peritoneum underneath it, that here makes up the posterior sheath of the rectus, will be seen the epigastric vessels, which should be seized, divided and ligatured, and sometimes pulled outward, and the sheath and peritoneum cut in a manner similar to the outer sheath. When blunt retractors are now passed into the peritoneal cavity and the abdominal wall put on the stretch, there is a very superior exposure of the whole pelvis and the right iliac fossa. Indeed, I have never before been able to command these parts so well until exposed by the incision, and particularly is it so if the gravity action is induced by a sand bag under the right hip or by by a Trendelenburg position judiciously used after the removal of infecting inflammatory fluids."

Willy Meyer gives in the *Journal of the American Medical Association* of Feb. 17, a similar method especially designed for certain complicated cases of appendicitis. He denominates it the *Hockey Stick Incision* on account of its shape. His incision differs from that of McBurney in some important particulars. For years Meyer has split the external oblique in the direction of its fibres, and makes this incision where the layer of abdominal muscles is thickest, namely, close to the anterior superior spine. The upper end of his incision as now adopted passes exactly midway between McBurney's point and the anterior superior spine, and then continues in a straight line toward the spot where the femoral artery is felt pulsating beneath Poupart's ligament. The incision begins about a half inch above the line drawn from the umbilicus to the anterior superior spine and ends one-half to three-quarters of an inch from Poupart's ligament. "The fascia of the external oblique and the following structures are split in the same line." The incision may now be lengthened either upward or from its lower end. At the lower end he proceeds in the following way: The peritoneal cavity is entered with the left forefinger which is pushed on to the point where the epigastric artery is felt pulsating; the knife is then carried in a horizontal line to the border of the rectus muscle. Should more room be needed the belly of the rectus can easily be pulled inward and the peritoneum incised beneath. When this wound is opened up with retractors it will be seen that easy access is had to the pelvic organs and the appendix, but some of the important advantages of the McBurney incision have been sacrificed to gain the larger operative space.

A decided improvement will be observed in the method described by Fowler, in the *Medical News* of March 3.

All incisions, he contends, should be so planned as to include removal of the appendix, and to accomplish this the technic demands free access to the base of the organ or the junction of the appendix with the cecum. For obvious reasons attempts to fix the base of the organ with reference to some point on the abdominal wall have proved futile. While the base of the appendix may be sometimes found as high as McBurney's point, in Fowler's experience it is more frequently located at a point "corresponding to the intersection of a line extending from one anterior superior spinous process of the ilium to the other, with a vertical line drawn half way between the median line and the right anterior superior spine." Having next considered in detail the functions of the various structures composing the abdominal wall and ascribing to each of the muscular and aponeurotic expansions its due value in resisting intra-abdominal pressure, and having drawn attention to the nervous and vascular supply of this portion of the wall, Fowler then describes in detail his method of operation designed to preserve as far as possible these normal anatomic relations. The operation is intended especially for those cases operated upon when the infectious process is still confined to the appendix itself.

The operation is based upon the same principles as that of the intermuscular incision of McBurney, but differs from that procedure in that it gives readier access to the contents of the ileo-cecal region and a larger working space without increasing the size of the external incision. The incision is thus planned:

I. *The Skin Incision.*—Commences at the upper rounded prominence of the anterior superior spinous process, runs transversely inward to the outer edge of the rectus abdominis muscle, whence it is curved downward and extended parallel to the edge of the rectus muscle for a distance of two and a half inches or more, according to the exigencies of the case. The skin, fat and fascia are divided and the triangular shaped flap with rounded corner dissected and reflected downward and outward, exposing the aponeurosis of the external oblique.

II. *The Incision of the External Oblique.*—A retractor is applied at the lower angle of the wound and another at the middle of the horizontal incision. Traction upon these in the direction of the fibres of the external oblique exposes the latter for a distance of three or more inches, if necessary. This structure is now opened in the direction of its fibres, two more retractors applied and the rectus exposed and likewise opened. The rectus muscle and the underlying deep epigastric artery and veins are now retracted strongly towards the median line and the aponeurosis in the opposite direction. A space of four inches in the transverse direction is thus exposed.

III. *The Incision of the Internal Oblique, Transversalis Muscle and Fascia and Peritoneum.*—All these layers are taken practically as one structure and are incised transversely in the direction of the skin incision. The incision is begun at the inner end where the rectus has been retracted. Access being gained at this point, first the finger is introduced and the incision completed. The operation having been finished, the parts are replaced and sutured in the following manner: The transverse incision is closed by a running catgut suture including the four structures. The external oblique is closed in the direction of its fibres and finally the skin by the subcuticular suture. Fowler advises kangaroo tendon for the external oblique. In closing the external oblique it is important to include in the suture the incised edge of the rectus sheath, care being taken not to include the muscle itself, as this might prevent prompt union of the aponeurosis.

Comment: Of these incisions that of Meyer will give the most abdominal space, and it is, therefore, applicable to more aggravated cases, indeed, to the worst forms of appendicitis; but it sacrifices important safeguards against post-operative ventral hernia. It should, therefore, be reserved for those where the McBurney, Weir and Fowler plans will not do, on account of the amount of space required for intra-abdominal manipulation. The last three procedures are closely related. They are all three founded on the principles of the McBurney operation, the last two differing from it only in certain modifications, which are intended to give more space. This they certainly do accomplish. The Weir and Fowler conceptions are really the McBurney operation combined with the features of the procedure independently originated by Battle, Jalaguier and Kammerer, in which the anterior layer of the rectus sheath is incised, the muscle pulled inward and the peritoneal cavity entered by an incision of the posterior layer of the sheath and the peritoneum in the same line. We believe the Fowler plan has some decided advantages over that of Battle. We have been much pleased with it on the cadaver.

CONGENITAL CYST OF THE THYROID GLAND, EXTIRPATION, RECOVERY.—Mr. Picque reports for Mr. Isambert, in *Revue de Chirurgie*, for February 10, 1900, the case of a cystic tumor of the thyroid, noticed at birth and which remained stationary until the patient was 5 years old. The growth then developed so much as to necessitate extirpation.

The tumor occupied the middle of the thyroid gland.

Histologic examination of the cystic walls showed that the tumor originated in the isthmus of the gland.

This is a very rare case, only six being recorded.

SUPPURATING PANCREATITIS; LAPAROTOMY; RECOVERY WITH A PANCREATIC FISTULA.—M. Guinard reports for M. Faure, in the *Revue de Chirurgie* for January 10, 1900, the case of a woman, aet. 22 years, who entered the hospital with fever and violent pains in the epigastrium; she was very much prostrated; the abdomen was very sensitive and slightly distended. Nothing definite being revealed on examination, she was watched for several days when it was thought she presented symptoms of perforation of the stomach, then again of appendicitis, and even of hematocele. After three days she became suddenly worse, so M. Faure decided to intervene by making an incision in the center of the epigastrium; he then discovered that the inferior portion of the liver was adherent to the anterior surface of the stomach; by raising the edge of the liver, and tearing several adhesions, he found a large pouch containing dark fluid pus, with sloughing debris. It was necessary to pass through the gastro–hepatic omentum. He inserted a drain surrounded by sterilized gauze and sutured very nearly the entire length of the abdominal wound. The patient recovered with a fistula, whence flowed a clear colorless liquid. Examination positively revealed that the secretion was pancreatic juice.

M. Guinard calls attention to the fact that the pancreatic fistula seals the diagnosis.

Even the examination of the sloughing debris, can help the diagnosis only when it is positive, for most frequently there is no trace of pancreatic tissue. The clinical aspect of M. Faure's patient was of one suffering from suppurating pancreatitis; a picture of which one must always bear in mind.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER, New Orleans, La.

CONTRAINDICATIONS TO ACCOUCHMENT FORCE IN ECLAMPSIA.—In *Obstetrics* for February appears an editorial under the above heading, calling attention to the general practice of accouchment forcé in eclamptic cases, and the dangers of such an unexceptional rule. Says the author: "The older we become and the more experienced, the less we will meet this pathologic giant among diseases with an inflexible rule."

Eclampsia is a supreme test in the concentrated crisis form of obstetric judgment, as well as resource. Death threatens in three directions, viz: toxemia, convulsions and shock. We are so anxious in the short time available ere death may come to advance to the attack with the entire rescuing force, anesthesia, elimination and delivery—all at once, the result is often, in the struggle to apply each first, a therapeutic and surgical crossfire. The author believes that if the convulsions could be held in check for sufficient time to secure thorough action and activity of all the eliminatives, a matter of from three to six hours, there would be a tremendous reduction in mortality, and almost no need of immediate emptying of the uterus. Delivery accomplished without traumatism or shock decidedly improves the eclamptic prognosis, but it generally increases vascular tension and temporarily adds to waste product in the tissues, and so favors both convulsions and shock while being done. Consequently the induction of labor should not be undertaken during the acute stage of eclampsia, when it is believed that the convulsions are being checked by elimination. If the toxemia is disappearing, pregnancy should not be interrupted; but should the treatment not gain on toxemia, delivery should be secured by the method nearest a physiologic expulsion. An eclampsia which excites labor is usually one in which immediate delivery is best, and an eclampsia which does not excite labor is one in which the toxemia and degree of asphyxiation is mild. Champetier, who sharply attacked Dubrosen for his enthusiastic advocacy of accouchment forcé, gives these statistic results of mortality:

After spontaneous labor, 18.96; after artificial labor, 30.04; and after accouchment forcé, 40.74, though, of course, it is fair to assume that the last class included the most severe forms. Tarnier had a mortality of 9.09 per cent. in cases of non-intervention. "But, after all, statistics can not prove of much help. We simply appear to ever keep the question of accouchment forcé in eclampsia open."

LIVE CHILD DELIVERED BY FORCEPS AFTER DEATH OF MOTHER. Dr. Fleischmann, of Buda-Pesth, reports a case of some medico-legal and obstetric interest, the third instance only of the successful use of the forceps after the death of the mother. The patient was a primipara, age 30, the subject of mitral and aortic incompetence. Dr. Fleischmann first saw her when she had been in labor at term for over twenty-four hours; the membranes had ruptured on the previous evening. The fetal head presented in the first position; its heart sounds were normal. The os was rigid, so an hourly hot douche was ordered. A few hours later Dr. Fleischmann was called again to the patient, who was clearly dying of dyspnea. Just as he had introduced one blade of the forceps the mother's pulse and respiration ceased. For about ten minutes his attention was turned to the mother, the blade being left in its place. All attempts to revive her proved useless; then he introduced the second blade and at once extracted an asphyxiated female child, who was resuscitated and successfully reared.

The first successful case of post mortem delivery of a child by the forceps is recorded by Heinricius of Helsingfors; the mother died suddenly at term of rupture of the aorta; immediately afterwards a large healthy male child was delivered by the forceps and reared. In the second case, recorded by Piskacek, the patient, a woman aged 28, died during her second delivery, of advanced heart disease. An asphyxiated child, weighing a little under 5 pounds, was delivered and revived, but died in 36 hours. In this instance, however, the pelvis was extremely kyphoscoliotic, so that delivery was not easy. Dr. Fleischmann publishes these interesting cases in the fourth number of the *Centralblatt für Gynäkologie* for this year. In a general or abstract sense the duty of the obstetrician seems clear in cases of this kind, but very natural objections are almost sure to be raised against any handling of the body of the mother.—Editorial in *British Medical Journal.*

Uterine Fibroids Complicating Pregnancy.—H. C. Coe (*New York Medical Journal*) states that the influence of pregnancy upon the growth of uterine fibroids depends greatly upon their more or less intimate relation to the uterus. A pedunculated subperitoneal growth may remain unchanged, while an interstitial tumor undergoes marked enlargement. A fibromyoma situated in the lower uterine segment, or displaced and impacted in the cul-de-sac may increase in size from obstruction to its circulation. In answer to the question whether young women with fibroids should be advised to marry, he states that in the majority of cases they give rise to no symptoms and are only discovered at the time of pregnancy. Any fibroid that gives rise to marked symptoms (hemorrhage, pain and pressure), should be regarded as a positive contraindication to matrimony. He favors conservative treatment and discountenances the interruption of pregnancy, if possible to prolong it until the fetus is visible.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Administration of Medicaments and Feeding by the Nasal Fossae.—There are circumstances which do not permit giving drugs and food by the mouth. Both the hypodermatic and rectal methods do not always give us entire satisfaction as substitutes for the oral, while the use of the esophogeal and stomach tubes is not by any means free from difficulty and danger even in well-trained hands.

For twenty years Dr. Salomon, of Savigné-l'Evêque, has depended in such cases on a procedure which never failed when other means did, viz.: It is to pour directly into the nasal fossæ, without any sound, from the spoon the medicine or the food, in liquid form, of course. It is simple and harmless.

The patient lies with his head thrown back, kept by an assistant in that position if agitated, or by the attendant's own hand if quiet. To facilitate matters cocain may be applied to the pituitary membrane, but it can be safely omitted.

The next thing now is to close one of the nares with cotton and bringing the spoonful to the opening of the other, watch carefully the respiratory movements and pour the liquid down into the nose exactly at the very commencement of an inspiration, and only then. The liquid by force of gravity flows down gently, being also slightly aspirated, and drops back of the glottis without touching it, on the pharynx, when it causes, of course, deglutition which carries it to the stomach.

Keep this manner of giving drugs and food as a last resource and then you will appreciate all its value when the usual means are inadequate, difficult, dangerous, in such cases as apoplexy, hysteric or eclamptic seizures, delirium, insanity, also in refractory patients and children.

The procedure is absolutely harmless; not a single accident ever occurred in its practice during twenty years, while its advantages are capital.

It does away with the difficulty met when patients are unable or unwilling to open their mouth, or to swallow the tube, struggling against the attendant.

Very often insane patients will succeed in getting out by the mouth the tube inserted by the nose and keep it between their teeth, stopping at once the capital operation of forced medication and feeding.

Although rarely, the introduction of the tube may cause suffocation; oftener unpracticed hands may inject bouillon or milk in the bronchi instead of in the esophagus. And not uncommonly expert attendants have seen hemorrhage, from a stomach ready to ulcerate, follow the contact of the inserted tube.

Pouring a liquid directly into the nasal fossæ never causes suffocation. Drugs that the mucous membranes hardly tolererate, such as spirituous preparations, for example the compound tincture of jalap, have been so given without causing spasms or coughing, owing to the fact that the epiglottis is not touched. The aversion for a number of drugs is overcome, as the tongue is not touched.

In children it is a precious method indeed.

It is altogether so easy and so harmless that it can be taught to any one. Nurses can do it, and your mind is comforted by the fact that you know your patients in your absence are having both drugs and food, the taking of which in practice is by no means an uncommon difficulty and a source of worry. The only weak point in the method is that it is slow and also insufficient as regards thorough feeding. Of course you can not think of pouring in this way several quarts of bouillon a day. It would, indeed, take time and patience; but the difficulty is avoided by using quality instead of quantity, for instance, yolks of eggs with milk. Then it would only take a few minutes to feed enough to maintain the patient's strength. The procedure may be known and practiced by many, but it is a fact that it is conspicuous by its absence in books on practice of medicine, and many practitioners will be glad to have heard of it. Try it.—*Le Progrès Médical*, January 13, 1900.

CROUPOUS PNEUMONIA IN CHILDREN.—Broncho-pneumonia has for so long been recognized as peculiarly the pneumonia of children that many still believe that croupous pneumonia is rare in them, and do not realize that about one-third of the cases of pneumonia in children are of this latter variety. The disease differs but little from that seen in the adult, but owing to peculiarities in the thorax and lungs in children it is more difficult to recognize by physical signs.

Three things should always be remembered when examining a child for croupous pneumonia. First.—The left lobe is most frequently affected, next the right apex. Second.—The disease may only be found in the apex or in the axilla and may not involve a whole lobe. Third.—The liver dullness extends to the fifth rib in front, to the seventh on the side, and to the ninth in the back, and that crying may cause it to extend considerably higher, particularly in the back.

Not infrequently physical signs are late in appearing and may not be found until after the crisis, and there have been undoubted cases of the disease where no physical signs were made out at all. Respiration is intensified on inspiration, the expiratory sound being very weak and at times almost absent. Before complete consolidation there may be heard only weakened respiration over the pneumonic area. When consolidation is completed bronchial breathing is heard, the sound on inspiration and expiration being very much alike. The so-called pathognomonic crepitant râle is oftener absent than present. Bronchial voice usually accompanies bronchial breathing, but it may be the first sound elicited. Palpation gives increased vocal fremitus over consolidation. In palpating better results will be obtained by using the edge of the hand instead of the palm; it is more sensitive, covers a smaller space, and is better adapted to the chest walls.

Percussion should come last, for children object more to this than to the other methods. Great care is necessary on account of the thin chest walls and the delicate lungs. The stroke should be very light or a tympanitic note will be obtained over a small consolidation or there will be vibrations from organs at a distance. The same location over the two lungs must be closely compared and percussion must not be made on one side during inspiration and on the other during expiration, as this will give a difference in the sounds. Early in the disease there is some impairment in the resonance that is later increased to slight dullness, but seldom to the same extent as found in the adult. The sense of resistance to the percussed finger should be noticed; it may be slight, but it is perceptible and is quite an aid at times.—J. PARK WEST, M. D., *The Cleveland Medical Gazette*, January, 1900.

Department of Therapeutics.

In charge of DR. J. A. STORCK, New Orleans.

PALATABLE QUININ MIXTURE FOR CHILDREN.—Greanelle, in a contribution on this subject in the *New York Medical Journal* of October 29, 1899, says that having had occasion to prescribe quinin repeatedly for young children, and being dissatisfied with the combination with syrupus yerbae santae, he made a number of experiments with a view of obtaining a pleasant and acceptable quinin preparation which could be continuously administered to children without their objection. The mixture is designed as a tonic and malarial prophylactic for children living in malarial sections. It will serve for active medication in acute cases of malarial disease in children of three years or younger by giving the larger dose at hourly intervals.

Greanelle finds that the children literally cry for it, and that it has frequently served as an excellent bribe, to be given immediately after a simple solution of quinin hydrochlorate in water when large doses of the drug are necessary. A teaspoonful of water carrying two or three grains of quinin muriate will be readily taken by any child with " a spoonful of pink medicine right after." Those who have little patients in large numbers will appreciate this.

(1)	Quinin hydrochlorate	gr. v-x;
	Alcohol	ʒi.
M.		
(2)	Oil of cinnamon,	
	Oil of anise of each	mxxx-xl;
	Magnesia	q. s.;
	Water	℥i.
M.	Let stand for some hours; filter.	
(3)	Mix 1 and 2 and add	
	Simple syrup	℥iii.
	Carmin, or cochineal solution	gtt. v.

Dose, one or two drachms as directed.

Saccharin in small quantities helps tor disguise the larger dose of quinin.

Small doses of Fowler's solution may be added if indicated, or sodium bromide for children made irritable by quinin.

Druggists will make this in quantity and keep it in stock if requested. It is simple, easily made and inexpensive.—*The Therapeutic Gazette.*

THE ACTION OF ANTIPERIODIC DRUGS ON THE PARASITES OF MALARIA.—Dr. Manaco and Dr. Panichi, of Rome, have lately published a preventive note in the *Rend. della R. Accademia dei Lincei* on the above subject.

In a preceding note these authors describe the mode of action of the parasite of the quartan type of fever in immediate contact with a solution of quinin, and in the above paper they have given the result of their researches on the parasites of spring tertian fever. On the very young forms the solution of quinin produces an increase in the normal ameboid movements of the parasites, which, however, after some time cease, the parasite then assuming a discoid form. The movements after an hour again become active. But when a drop of the quinin solution acts on a preparation of the blood where the adult parasite form has been fixed, one observes that the latter is expelled from the red corpuscle, as happens with the quartan parasites. The more developed forms (third phase of development) contract under the action of quinin, assuming a spherical form which makes them appear smaller, and in those still larger the expulsion of some pigment granules into the plasma is observed. In the parasites, finally, about to sporulate, that have pigment collected in the central portion and the striæ of division project little, under the action of quinin the pigment is arranged in a more extensive radius, the granules, before immobile, become mobile and the striæ more marked, so that the spores can be distinguished. If these, instead, be little visible, in the same conditions of experiment, they are seen to separate from one another, and they may be individually transported by the liquid cement.

To prevent the discoloration of the red corpuscles the writers have added to the watery solution of bisulphate of quinin a few drops of isotonic solution, gr. 0.90:100 of NaCl. What is notable in these researches, and which confirms that already observed for the quartan type, is that, to obtain the phenomenon of the expulsion of the parasite from the red corpuscle, solutions of quinin much weaker than those adopted in their observations in the blood of quartan cases are necessary. The parasite of the tertian is, therefore, more sensitive to the action of quinin than that of the quartan.

From another series of researches they deduced that the resistence of the tertian parasite to quinin varies in different patients, and, in fine, with other experiments made they were able to arrive at the conclusion that the action of the quinin on the endoglobular parasite of spring tertian fever can be summarized as follows: (1) In very dilute solution it excites it; (2) in less dilute solutions the stimulation, which reaches its maximum phase when it produces the expulsion of the parasite from the red corpuscle, is preceded by a brief contraction of the latter; (3) in strong or concentrated solutions it paralyzes it.

From other observations the authors were obliged to admit that with the recurrence of the infection the resistance of the parasite to the action of quinin was augmented. Meanwhile they announce that the crescentic forms (those of the estivo-autumnal fever) do not feel any action in contact with the quinin solution.

As to the dose of quinin suitable for producing the cure of spring tertian fevers, Drs. Monaco and Panichi, calculating the doses corresponding to the solutions adopted in determinate figures, found in experimenting on malarial patients that the dose of quinin which stimulated the parasite in patients suffering from tertian not only did not impede the febrile attack, but frequently rendered it of longer duration. On the contrary, the doses which correspond to solutions a little weaker than that of the minimum limit retard the febrile paroxysm, which is milder and of shorter duration.

With the doses, however, that *in vitro* produce the expulsion of the parasite from the red corpuscles or its permanent contraction, the febrile attack does not happen. Nevertheless, taking into consideration the individual resistance of the patients the authors believe that the doses of quinin usually given are too large, and that the proper dose in spring tertian is from half a gram to a gram of bisulphate of quinin. Finally, in a patient suffering from double spring tertian, observing the forms expelled every day and at all hours, with solutions of various strengths, they were able to conclude that while in the hours which immediately followed the febrile paroxysm the resistance of the parasite to the action of quinin increases,in the second period of apyrexia (six hours before the attack) the resistance diminishes until it reaches a minimum, when the temperature has almost arrived at its acme. Afterwards the resistance commences to augment, while the febrile paroxysm is extinguished.—*The Therapeutic Gazette.*

FEEDING OVARIES IN CHLOROSIS.—Moscucci (*Accad. dei Fino-cratici di Siena*, 24, 4, 1899) claims to have secured considerable improvement both in the general condition and the blood of chlorotic patients after exhibition of the fresh ovarian tissue. Beneficial results were also noticeable in dysmenorrhea.

ELECTRICITY IN PRURITIS.—Legros (*Thèses de Paris,* 1898, 1899) advocates the various forms of franklinization (or static electrization) for the treatment of pruritus, claiming about 70 per cent of cures by this method.—*The Medical Age.*

VASODILATORS.—Capitan (*La Médecine Moderne*) advises tetranirate of erythrol and the hexanitrate of mannitol as vasodilators, more permanent than nitrite of amyl and nitro-glycerin. The dose is about six milligrams, the delay after administration one hour, the duration of effect six hours. Hugh Walsham has reported favorably to the British Medical Association on the use of the first in interstitial nephritis, Raynaud's Disease, etc.—*The American Therapist.*

FOR SEA SICKNESS.—

℞	Acid citrici	ʒ ii
	Aquæ destillatæ	℥ iv
	M. Ft. sol.	
	Potassii bromidi	
	Potassii bicarbonatis	aa ʒi
	Aquæ destillatæ	℥iv
	M. Ft. sol.	

Sig. A tablespoonful of each solution mixed together, and taken during effervesence.—HARE, *Penna. Med. Journal.*

THE TREATMENT OF HYSTERIA IN YOUNG GIRLS.—The *Journal de Médecine de Paris* for December 3, 1899, gives the following:

1. Hot poultices of belladonna leaves, moistened with oil of hyoscyamus, to be applied to the abdomen.

2. The patient to be kept in absolute repose and silence during the menstrual period.

3. The patient to be plunged daily in a bath of linden at 98.6 degrees F. for an hour and a half. To the bath the following decoction should be added:

Linden flowers	4.500 grains.
Boiling water	4 pints.

4. The following enema should be administered on leaving the bath and retained:

Valerianate of ammonium	4 ½ grains.
Powdered camphor	3 ¾ grains.
Yolk of egg	1
Decoction of valerian	3.000 grains.

M.

5. Five days before and five after several successive menstrual periods, from 30 to 40 drops, in divided doses of 10 drops each, should be administered of an alcoholate of the leaves and roots of anemone pulsatilla.

6. Should this treatment fail, after three months, should be administered, five days before, during, and five days after several successive menstrual periods, 75 grains of tincture of viburnum prunifolium, from 40 to 50 grains being administered daily, divided into two doses.

7. Inhalations of ether or chloroform in small quantities in case of acute crises.—*New York Medical Journal.*

For Obesity.—A New York physician has used the following with marked success lately:

℞ Thyroid powder	0.05
Ferratin powder	0.4
Quinin sulphate	0.1

M. Take one powder every four hours.

—*The American Therapist.*

Mercury Hypodermatically.—Lambkin, of the British army, reported to the British Medical Association on the hyperdomatic use of mercury in syphilis. In 20,000 cases he had had one localized abscess. His formula is:

℞ Hydrargyri	1
Lanolin	2
Ol. carbolati (1:20)	4

S. Inject mx. (=⅔ *c. c. m.*) in the buttock, once a week. Treatment lasts eight to twelve months.

—*Ibid.*

Epilepsy:

℞ Lithii Bromidi	
Potassii bromidi	
Sodii bromidi	
Calcii bromidi	a. a. 4—(ʒi.)
Syrupi aurant. corticis	30—(℥i.)
Aquæ	q. s. ad. 90—(℥iii.)

M. Sig.: Teaspoonful in water after meals, to prevent recurrence of convulsive seizures.

—*The Therapist.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING,
New Orleans.

HICCOUGH AND PHOTOPHOBIA AS REFLEX MANIFESTATIONS OF POSTNASAL ADENOIDS.—Doctor Thomas, of Marseilles, describes two most interesting cases showing some unusual and distressing reflex systems occurring in children affected with adenoid growths of the naso-pharynx. The first case was that of a child, six years of age, who was taken suddenly after a short carriage ride with violent vomiting and a most distressing hiccough. The latter symptoms lasted for forty-eight hours without cessation and then disappeared completely, but for two years and a half following this, patient was subject to spells of vomiting coming on with the slightest provocation, and varying in duration and intensity The hiccough did not recur until one day, after spending a half–hour in a crowded omnibus, he was attacked with a severe fit of vomiting and the hiccough was renewed. This attack continued for eight days and the vomiting became so frequent that the patient became much depressed by it and was sent to the country to recuperate. The change produced a favorable effect, but the trouble was brought on again by a return to the city, and it was deemed necessary to transport him a second time to the country. About this time the little patient began to complain of difficulty in breathing through the nose, and as this increased the hiccough and vomiting spells became more aggravated and added to this laryngeal spasm, and slight strabismus came on. An examination of the post-nasal space showed the presence of a large adenoid growth, which, when, removed caused a complete cessation of all the symptoms, and a sojourn in the country restored the boy to good health. This, in view of the fact that all other remedies had failed completely to relieve the patient, is proof conclusive that the adenoids were directly responsible for those grave reflex phenomena.

The second case was a boy fifteen years old, who began to suffer with severe photophobia, which was more marked in the right eye. Examination of the eyes showed nothing abnormal. Adenoid growth of considerable size was found in the nasopharynx, and a small septal spur on the right side. Removal of these causes of nasal obstruction was immediately followed by relief of the photophobia.—*Revue Hebdomadaire de Laryngologie d'Otologie, de Rhinologie*, January 27, 1900.

A CASE OF A LEECH IN THE LARYNX.—In the January number of the *Monatschrift für Ohrenheilkunde*, Doctor M. Tsakyroglous, of Smyrna, reports a case of a man forty-five years of age, who came to him with a history of expectoration of blood and difficult respiration. The patient had recently been in a community where he had been compelled to drink well water, and suggested to the physician that he might have swallowed a leech. This was found to be the case, for when an examination of the larynx was made a leech was seen lying at the base of the epiglottis and attached to the false vocal cord. The removal of the parasite was easily effected with the aid of Fauvel's forceps. It had remained in the patient's larynx for eight days. This form of parasite is common in Smyrna and about Constantinople, and is frequently found in the throat and stomach of horses and cows. The same author mentions another instance in which he removed a leech from the posterior choana of a woman.

A CASE OF RETRO-PHARNYGEAL ABSCESS OF AURICULAR ORIGIN.—Doctor Urbano Melzi, of Milan, speaks of the infrequence with which retro-pharyngeal abscess has been traced to a suppuration of the middle ear, and has been able to find only twenty-two cases cited in medical literature. His patient was a child two years old who came under his care for suppuration of both ears. Perforations existed in both tympani and the discharge of pus was considerable. The discharge ceased within three weeks under a careful treatment with boric acid solution and instillations of borated alcohol. A month later a recurrence of the suppuration took place under the influence of a severe coryza and bronchitis. A few days later the child complained of pain in the throat and was feverish and restless and snored at night. Some degree of stiff neck developed and the sub-maxillary region became red and swollen. The nasal and pharyngeal mucous membranes were deeply congested. Little relief was obtained by the use of gargles, etc., and the patient began to have attacks of suffocation. A day later an enormous retropharyngeal abscess was discovered and a free incision gave exit to a large quantity of pus. No disease of the vertebrae could be found, and a bacteriologic examination of the pus from the ear and the pharynx showed the presence of similiar bacteria in both.

The patient made a recovery.—*Journal of Laryngology*, January, 1900.

ENZYMES IN THE TREATMENT OF NASAL POLYPI, ANGIOMA OF THE NOSE AND CHRONIC OTITIS.—Under this title Talbot R. Chambers, of Jersey City, at the last meeting of the American Medical Association, related his experience with the new drug, enzymol, and extolled its virtues very freely in connection with the treatment of suppurative affections of the middle ear and of polypoid tumors of the ear and nasal cavities.

Enzymol is a pure solution of a proteolytic enzyme prepared by a direct extraction from the peptic glands of a pig's stomach. It is a stable compound under ordinary circumstances and is used diluted with an equal volume of water. Its action is similar to that of pepsin and of peroxide of hydrogen in that it attacks and decomposes dead organic matter while not affecting healthy parts.

The author reports most encouraging results from its use in those chronic forms of suppuration of the ear which have resisted all the ordinary means of treatment and would otherwise require surgical interference. In these cases the patient is given a small vial of the enzymol diluted with equal parts of water, and instructed to instill five or six drops into the ear after syringing it out thoroughly with warm water, this to be done three times a day. Polypoid granulation tissue in the ear and polypi of the nose disappear upon continued applications of enzymol, and the purulent discharge rapidly dries up. The writer has used it extensively in his clinic work, and reports a few cases in verification of his claims for the remedy.

Miscellaneous.

Sugar from Watermelons.—A farmer and gardener named Hanz, of Bowling Green, Ky., has recently made an excellent quality of syrup from watermelons, according to *Irrigation Age*, which states that he will shortly attempt to convert some of the syrup into sugar, and expects to be successful. The same paper gives the following report of an interview with him:

"From 18 melons, weighing from 20 to 25 pounds, we made two gallons and one pint of syrup. We cut the melons in halves, cut out the pulp, ground it in a cider-mill, and pressed out the juice. We boiled the juice in porcelain kettles on the kitchen stove for twelve hours. With a cider-mill and hot air or steam evaporator, two men can make 25 or 30 gallons of syrup per day. At the above figures it would take about 270 melons to make 30 gallons of syrup, worth $15. Melons would be worth at wholesale about $5 or $6, and it would take two or three days to haul and sell them at market. With a mill and an evaporator in the melon patch, a farmer and one or two hands could realize 100 per cent. more by making them into syrup and feeding the refuse to hogs, cattle, horses, and chickens, which eat it greedily.—*Literary Digest.*

[We know of sugar having been made from watermelons many years ago, but the man who did it, an enthusiast, went broke because the cost of manufacture was too great —Eds.]

Diabetes Mellitus of Apparent Bacterial Origin.—Dr. J. P. Sheridan, in the *New York Medical Journal* of February 17, 1900, relates the successful treatment of four cases of diabetes mellitus of supposed bacterial origin, the remedy employed being Arsenauro, given in doses ranging from eight to fifty-five-drop doses three times a day. The cases are briefly detailed, the improvement being rapid and notable in each instance. The article concludes with the argument that the bromides of gold and sodium contained in the remedy act by saturating the system, arrest the bacterial activity by killing the micro-organisms, or by neutralizing their toxins. The tolerance of the drug in large doses is emphasized.

Medical News Items.

The Louisiana State Medical Society will meet in New Orleans, April 19, 20, and 21. Members are urged to be present. With a view to making the program more interesting the Chairmen of the several sections have arranged for each a subject for general discussion. Members will find the list of these below, so that if they have anything of importance bearing on any of these questions they may write a paper and send the title on or before April 5, to the Committee of Arrangements. Any paper on any point of medical or surgical interest will be listed on the program among the papers in the Miscellaneous Section. To appear in the program, the titles of these must also be sent to the Committee of Arrangements by April 5.

Address all communications to the Committee of Arrangements, P. O. Box 778, New Orleans, La.

Preliminary Program.

Titles of Sections with Subjects for General Discussion.

General Medicine: Tuberculosis.

Surgery: Local and Regional Anesthesia in its Application to Minor and Major Surgery.

Note.—Any other papers on Surgical subjects should be sent as above directed.

Mental Diseases: The Care and Treatment of the Insane.

Materia Medica: No subject announced.

Diseases of Children: Measles and Small-pox in Children.

Note.—A. First or second attack; B. Age at which complications were more frequent; C. Nature of complications; D. How was antisepsis of the mouth, nose, lungs and skin carried out; E. Was balneation resorted to; F. Effects of Vaccination of pregnant women on their fœtuses as regards immunity to vaccinia and to variola.

Obstetrics and Gynecology: 1. Surgical Aspect of Salpingitis. 2. Electricity in Gynecology.

Ophthalmology: The Prevention of Blindness; from 1. Ophthalmia Neonatorum; 2. Sympathetic Ophthalmia; 3. Corneal Ulcers; 4. Acute Iritis and Glaucoma—Their Differentiation.

Note.—Observations upon these subjects are solicited from all members of the Society. Papers on all matters pertaining to Diseases of the Eye are solicited and should be sent in as soon as possible in the manner directed above.

Otology, Laryngology and Rhinology: On the Management of Foreign Bodies in the Air Passages, with the report of a few cases, being the address of the Chairman of this Section.

Medical Jurisprudence: "Pullen Case" from a Toxicologic Standpoint.

Dermatology: The Commoner Affections of the Feet and Hands and Their Treatment.

Oral and Dental Surgery: Restoration of Symmetry of the Face by Mechanical Means after Disfigurement Resulting from Disease, Accident or Operation.

Quarantine: Variola.

Note.—In the light of the prevalence of this disease throughout the State, especial attention is called to the phases of this question.

Bacteriology: The Present Status of Blood Examination in Bacteriologic Laboratories for the determining of Malaria and Typhoid Fever.

Anatomy and Physiology: Vivisection is a Necessity for Medical Progress.

Genito-Urinary Surgery: Stricture of the Urethra. A. Duration of the Disease. B. Bladder Complications, if any. C. Method of Treatment.

Note.—Members are requested to bring up any other points which may be suggested by the above.

Miscellaneous Papers:

1. Improved Method of Vaccination. 2. On the Successful Treatment of Variola, by Dr. V. Lehmann.

3. Complete Transposition of Viscera, Report of a Case, by Dr. S. P. Delaup.

4. Report of a case of Recurrent Dermatitis Exfoliativa, by Dr. A. R. Robertson.

5. Suprapubic Cystotomy, for the Purpose of Retrograde Catheterism in a case of Complete Laceration of the Male Urethra, by Dr. C. J. Ducoté.

6. The Physiologic Treatment of Typhoid Fever, by Dr. T. S. Dabney.

7. A case of Gunshot Wound of Abdomen with three Perforations of Colon and a Graze Wound of Stomach. Laparotomy.

Recovery. 8. Typhoid Fever in Childhood, with a report of three cases, by Dr. E. D. Fenner.

[Other papers will be listed as their titles are sent in.]

All sessions will be held at Tulane Medical Department, Canal and Villeré streets.

Committee of Arrangements:

ISADORE DYER, M. D., Chairman.
E. M. DUPAQUIER, M. D.
JOHN F. OECHSNER, M. D.
New Orleans, La.

THE LOUISIANA STATE BOARD OF HEALTH visited the Quarantine Station, the Hospital Lazaretto and Port Eads Station, on March 13, consuming the entire day in the trip. The object was the inspection of the quarantine apparatus and the stations, all of which were found ready for the summer work. The party consisted of the following members of the Board and invited guests: Dr. Edmond Souchon, president of the Board; Dr. C. T. T. Tarlton of Grand Coteau, Dr. Owen, of Whitecastle, Dr. Nolte, Dr. McCutchon; Dr. Kohnke, Dr. Isadore Dyer, Dr. J. B. Bonney, Mr. Locke Breaux, Col. Zacharie, the Count de Lafayette, of Paris, France, Drs. A. R. Reynolds and F. W. Riley, health commissioners of Chicago, and Superintendent J. S. Landry of the Grand Isle Railroad.

The party boarded a special train on the Grand Isle Railroad at 7:15 o'clock in the morning. Breakfast was served in Superintendent Landry's private car. The run through to Buras was made in a little over two hours. At Buras the party was met by Dr. Wilkinson of the Quarantine Station, who had come up aboard the quarantine tug Assistance from the station to convey the party down to Port Eads, the Lazaretto and back to the station, and finally to Buras, where the special train was in waiting to convey them to the city.

Drs. Reynolds and Riley were both much impressed with the thoroughness of the plant and the equipment for quarantine measures.

THE SAMUEL D. GROSS PRIZE OF ONE THOUSAND DOLLARS.—No Essay which the Trustees deemed worthy of the prize having been received on January 1, 1900, they hereby announce that the prize will be awarded on October 1, 1901.

The conditions annexed by the testator are that the prize "Shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page, it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 219 S. 13th St., Philadelphia, on or before October 1, 1901.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

W. W. Keen, M. D.,
J. Ewing Mears, M. D.,
J. Chalmers da Costa, M. D.,
Philadelphia, February 20, 1900. *Trustees.*

The Louisiana State Dental Society met February 23 and elected the following officers: President, Dr. C. V. Vignes; first vice president, R. L. Zelenka; second vice president, Dr. A. L. Plough; treasurer, Dr. C. Mermillod, Sr.; recording secretary, Dr. R. H. Welsh; corresponding secretary, Dr. C. M. Gibbons.

During the session of this society special clinics were held at the Eye, Ear, Nose and Throat Hospital on the following subjects: "A Caldwell-Luc Operation for Chronic Empyema of the Maxillary Antrum," by Gordon King, M. D.; "Combination of Amalgam and Gold in Filling Teeth," by C. Mermillod, Jr.; "High and Low Fusing Porcelain Inlays," by P. A. Michel; "The Zelenka Blowpipes," by R. L. Zelenka; "Cast Gold Fillings," by P. A. Michel.

The State Board of Dental Examiners met February 24th for the purpose of examining candidates for license to practice.

DONALDSONVILLE, LOUISIANA, passed an ordinance in February compelling the vaccination of all the residents. The fulfilment was accomplished by the health officer and police; non-compliance was made punishable by a fine of $5 or twenty-four hours imprisonment, or both.

QUARANTINE APPOINTMENTS: Dr. N. C. Lanier to Rigolets Station; Dr. Percy Ahrons to La Ceiba, Spanish Honduras.

DR. P. B. MCCUTCHON, of New Orleans, has been elected by the State Board of Health to serve as delegate to the Annual Conference of State Boards of Health, at Atlantic City, June 1 and 2.

PHYSICIANS MUST QUALIFY.—The State Board of Health is preparing a list of resident physicians in the State, and would like those who hold certificates from the State Board of Medical Examiners to come forward and register.

The present law to regulate the practice of medicine, surgery and midwifery (Act No. 49 of 1894), went into effect in July, 1894. Persons not legally registered prior to that date can only acquire the right to practice medicine in any of its branches in Louisiana by, first, receiving a certificate from the State Board of Medical Examiners; next, recording that certificate with the clerk of court in the parish where the applicant resides, and finally surrendering the certificate to the secretary of the State Board of Health for registration. The State Board is required by law to file all certificates registered, and this they are endeavoring to enforce.

A CASE OF PLAGUE IN SAN FRANCISCO was reported early in March. Prompt measures of isolation and disinfection prevented any spread of the disease.

THE EYE, EAR, NOSE AND THROAT HOSPITAL FESTIVAL has been fixed for Sunday and Monday, June 24 and 25, at the Fair Grounds in New Orleans. Quite a number of prominent citizens have interested themselves in making this a success for the benefit of the above hospital, most deserving of public consideration for the broad charity it dispenses.

THE CHARITY HOSPITAL RESIDENT AND EXTERNE STUDENTS successful in securing appointments at the recent examination were the following:

Resident Students—H. E. Bernadas, C. A. Cobb, James Gibbons, Alfred Jacoby, Joseph Levy, W. T. Richards, W. W. Samuel, T. C. Sexton, H. F. Terry, A. Wilkinson.

Externes—P. E. Bechet, Howard Clark, A. E. Eustis, E. B. Hands, D. F. Harang, C. H. Walliblich, E. M. Williams, C. T. Howell, A. J. R. James, A. A. Kennedy, J. F. Points, J. A. Price, P. B. Salatich, Jr., S. K. Simon and G. J. Tusson.

THE WESTERN OPHTHALMOLOGIC AND OTO-LARYNGOLOGIC ASSOCIATION will hold its next annual meeting in St. Louis, April 5, 6, 7, 1900. A most interesting scientific and entertainment program has been prepared.

THE TWENTY-FIFTH ANNUAL MEETING OF THE AMERICAN ACADEMY OF MEDICINE will be held at "The Shelburne," on the Beach at the end of Michigan Avenue, Atlantic City, N. J., on Saturday, June 2, and Monday, June 4, 1900. A number of interesting papers are promised.

DR. H. R. CARTER, U. S. M. H. S., has been ordered to Havana, Cuba, as quarantine officer at that port.

Bibliographia Medica is the name of an international bibliography of medical sciences, to take the place of the *Index Medicus*, and to issue from the Institute of Bibliography of Paris, 93 Boulevard St. Germain, under the direction of M. Marcel Baudoin. The subscription price will be 60 francs for all countries outside of France.

The Journal of the American Medical Association has adopted an innovation in the index, using the caption "Contents and Digest" instead of "Contents," as heretofore. The change carries with it a synopsis of each leading article, etc., as a guide to the reader, and is suggested as a time-saver to those who do not wish to read in detail. To the reviewer this change may prove of service, but we doubt its advantage to the general reader or to the *Journal* itself, as it encourages the more superficial reading of what may be valuable material, and it moreover adds materially to the labor of the editorial staff.

DR. R. L. RILEY has been appointed Assistant Coroner for the district of Algiers, in accordance with the new charter.

The Seaboard Medical Journal has just appeared, coming from Norfolk, Va., with a number of bright pages, under the editorship of Dr. L. Lofton.

THE MEDICAL DEPARTMENT TULANE UNIVERSITY will hold its commencement, Wednesday, May 2, 1900. The attendance for the session just closing amounted to a total of 424 students.

THE JOURNAL announces that our Dr. Chassaignac has been blessed with a daughter during the month just passed.

DIED.—DR. ALEXANDER JOHN GUSTAVUS DEVRON departed this life on March 24, 1900, in the sixty-fifth year of his age. He was one of the best known general practitioners in the lower section of this city where he had a large clientèle. Dr. Devron was a member of the Louisiana State Medical Society, and of the American Public Health Association. He had been connected with other medical and scientific bodies, and was at one time president of the Sanitary Association of the Mississippi Valley. Dr. Devron had contributed valuable medical literature and had made deep studies of the history of Louisiana.

He leaves a wife and four children to whom the JOURNAL extends its sympathy, particularly so to his son, Dr. John A. Devron.

THE LOCAL TELEPHONE COMPANY has announced a general increase in rates from April 1. Physicians are additionally concerned from the fact that they seem to be discriminated against, to the extent of being asked a higher rate than others for residence telephones, under the guise of "professional service." We are unaware that any other line of professional work has been included in said professional service. Besides, we do know that physicians are charged regular business rates for their office phones and, inasmuch as quite a proportion have both a residence and an office service, it strikes us as unjust to try to make them pay more than other people at their residences. However, as the Railroad Commission have taken the whole matter in hand, we shall say nothing further for the present, believing that the remedy would still be in the hands of a united local profession in the event of a failure of relief through other agencies.

THE CITY BOARD OF HEALTH is threatened with inanition by the failure of the City Council to make sufficient appropriation for its maintenance. Citizens are apt to expect a great deal from their health boards, but apparently wish to pay very little for the protection they look to from them. We hope that a solution of the difficulty will be found and may revert to the subject editorially in due time.

Book Reviews and Notices.

International Clinics, Vol. III. 9th series, 1899, J. P. LIPPINCOTT & Co. Co., Philadelphia, 1899.

This volume contains thirty-three articles by different writers. The article by Prof. G. Gärtner, of Vienna, on some improvements in dairy, technics and their medical importance, as also the article by Dr. Louis Leutenbach, should be carefully read by every physician.

We find much of interest in the volume and commend it to the progressive physician. STORCK.

A Practical Treatise on Materia Medica and Therapeutics, by ROBERTS BARTHOLOW, M. A., M. D., LL. D. Tenth Edition, Revised and Enlarged. D. Appleton & Co., New York, 1899.

The medical profession is well acquainted with this work of Dr. Bartholow, and in many respects it deserves the high rank it holds among works of its kind; but we question the wisdom of withholding from mention many preparations which Dr. Bartholow has seen fit to ignore in his work. In our review of the ninth edition, 1897, we made mention of the omission of formaldehyde and of taka-diastase and now notice a repeated omission. When a drug has proven itself of merit, standard works on materia medica and therapeutics might at least mention them. With such exceptions as these we have the highest praise for Dr. Bartholow's work. STORCK.

A Practical Treatise on Diseases of the Skin for the Use of Students and Practitioners. By JAMES NEVINS HYDE, A. M., M. D., and FRANK HUGH MONTGOMERY, M. D. Fifth and Revised Edition. Lea Bros. & Co., Philadelphia and New York, 1900.

This excellent work has always occupied a prominent position among the text books and reference volumes in dermatology. Its revision is evidenced throughout and the illustrations have been notably improved over the previous volumes. New chapters have been added on recently recognized diseases, while the same general scheme of arrangement has been followed which was used in the former editions. The book is thoroughly impressed with the individuality of its author, which makes it valuable, although it may be considered a fault in a text book.

DYER.

A Text Book of Embryology for the Use of Students of Medicine. By JOHN CLEMENT HEISLER, M. D. W. B. Saunders, Philadelphia, 1899.

Too much can not be said of this valuable contribution to the texts. It is characterized by a clearness of description, so essential in a book dealing with a subject somewhat abstruse. The illustrations, 190 in number, are well selected and judiciously placed with reference to the text. The publishers have done their part, and altogether have helped the author in presenting a useful and commendable work. DYER.

Dictionary of Medical Terms. By H. DE MERIC, Member of the Royal College of Surgeons of England, etc. William Wood & Co., New York, 1899.

These two volumes, French-English and English-French, fill a need long felt among English speaking readers of French medical literature. The arrangement seems to have been done with care, and it is remarkable that the American publishers should have used such poor paper for a book which must be used so often. DYER.

Practice of Medicine: A Manual for Students and Practitioners. By GEO. E. MALSBARY, M. D. Lea Bros. & Co., Philadelphia, 1900.

In this manual of 404 pages, Dr. Malsbary gives us a brief but reliable epitome of everything that is likly to engage the attention of the medical student. Manuals of this kind have special value in that they present the most recent advances in medicine in such a form as to be easily comprehended by the medical student. STORCK.

The Abdominal Brain and Automatic Visceral Ganglia. By BYRON ROBINSON, B. S., M. D. The Clinic Pub. Co., Chicago, 1899.

The book commences with an historic sketch of the developmental knowledge of the sympathetic nerves, and ends with the sympathetic relation of the genitalia and olfactory organs. In the treatment of the subjects, Dr. Robinson shows much originality of thought, and a perusal of the book can not fail to prove profitable. The study of the solar plexus is of so much importance to all of us that any contribution to our present knowledge should be eagerly sought after. The publishers' part of the work is not up to the standard. STORCK.

A Manual of the Practice of Medicine. Prepared Especially for Students. By A. A. STEVENS, A. M., M. D. W. B. Saunders, Philadelphia, 1899.

This work serves as an outline of the practice of medicine, standing midway between the quiz compend and the text book; the subjects are presented in an easily assimilable form. The student will do well to own a copy and use it it often for review. The book is bound in flexible leather, and the typographic work is good. STORCK.

Progressive Medicine. A Quarterly Digest, etc., Vol. IV. December, 1899. Edited by HOBART AMORY HARE, M. D. Lea Bros. & Co.. Philadelphia and New York, 1899.

We are glad to notice the usual standard maintained in this volume. The subjects discussed deal especially with diseases of the digestive tract, kidneys, etc., while a special chapter is devoted to recent formulæ in particular diseases, an alphabetic list of which is given.

Transactions of the Mississippi Valley Medical Association. 25th Annual Session, Chicago, October, 1899. Vol. 1. HENRY E. TULEY, M. D., Secretary.

Some four hundred and seventy odd pages are filled with the proceedings of this Association, composed of men well known in the profession. Many of the articles have been already published, but this in no wise detracts from the value of the publication.

Christian Science. An Exposition of Mrs. Eddy's Wonderful Discovery, Including its Legal Aspects. A plea for Children and other helpless sick, by WILLIAM A. PURRINGTON, Lecturer in the University and Bellevue Hospital Medical College, etc. E. B. Treat & Company, New York, 1900.

One need only notice the frontispiece of this work to appreciate the argument; as the author says most aptly in his preface: "One object lesson is worth a wilderness of words." This cut shows a child's foot, gangrenous to the bones and tendons above the ankle, brought to this state by Christian Science.

The book contains a series of papers prepared from time to time by the author for leading lay and medical periodicals. The question is presented from the legal and humane points of view, and from each standpoint, the subject is well handled.

On reading these articles as with all others which have come to us, we are persuaded that it is only a question of time when the victims of the evil of Christian (?) Science will themselves constitute a destroying angel of vengeance. Meantime the law should operate for the protection of the innocent and ignorant. DYER.

PUBLICATIONS RECEIVED.

Climatic Resources of the Sacramento Mountain Region, 1899.

General and Local Anesthesia, by Aime Paul Heineck—G. P. Engelhard & Co., Chicago, 1900.

A Manual of Modern Surgery, by John B. Roberts, M. D.—Lea Bros. & Co., Philadelphia and New York.

Diseases of Women, by E. C. Dudley, M. D.—Lea Bros. & Co., Philadelphia and New York.

Diseases of the Nose and Throat, by J. Price-Brown—The F. A. Davis Co., Philadelphia, New York, Chicago, 1900.

Scattered Leaves from a Physician's Diary, by Albert Abrams, M. D.—Fortnightly Press Co., St. Louis, Mo., 1900.

Transactions of the American Pediatric Society, 1899—The Archives of Pediatrics, 1899.

Surgical Pathology and Therapeutics, by John Collins Warren, M. D.—W. B. Saunders, Philadelphia, 1900.

International Text-Book of Surgery, Edited by J. Collins Warren, M. D., and A. Pearce Gould, M. S.—W. B. Saunders, Philadelphia, 1900.

Diabetes Mellitus and Glycosuria, by Emil Kleen, M. D.—P. Blakiston's Sons & Co., Philadelphia, 1900.

Tulane Alumni Association, Constitution, By Laws and List of Members, 1900.

REPRINTS.

An Experimental Study of Aspirin, a New Salicylic-Acid Preparation. By F. C. Floeckinger, M. D.

Imperfect or Deficient Urinary Excretion as Observed in Connection with Certain Diseases of the Skin. How Far has Specialism Benefited the Ordinary Practice of Medicine? By L. Duncan Bulkley, M. D.

Le Karnice, Premature Burial—Its Prevention. By Emile Camis, Esq.

Strangulated Hernia. By Parker Syms, M. D.

A Preliminary Investigation of the Theory of the Inoculation of Malarial Fever Through the Agency of Mosquitoes. By Albert Woldert, M. D.

Alcoholic Gastritis. By J. A. Hofheimer, M. D.

A Case of Cerebral Hemorrhagic Pachymeningitis with Pseudo-Bulbar Palsy. The Diagnosis of Nervous Syphilis. Medical Education. By Charles W. Burr, M. D.

Sterility and Pelvic Deformity. By Joseph Brown Cooke, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

FOR FEBRUARY, 1900.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)	2	3	5
" " Intermittent			
" " Remittent			
" " Congestive	3		3
" " Typho		2	2
" Yellow			
" Typhoid or Enteric	6	2	8
" Puerperal	1		1
Influenza	6		6
Measles	14	2	16
Diphtheria	3		3
Whooping Cough			
Apoplexy	11	6	17
Congestion of Brain	3	4	7
Meningitis	11	2	13
Pneumonia	71	51	122
Bronchitis	18	14	32
Cancer	7	2	9
Consumption	35	30	65
Bright's Disease (Nephritis)	26	9	35
Uremia	1	1	2
Diarrhea (Enteritis)	9		9
Gastro-Enteritis	2	2	4
Dysentery	3	1	4
Hepatitis	1		1
Hepatic Cirrhosis	4	3	7
Peritonitis	3	1	4
Debility, General	3	6	9
" Senile	16	11	27
" Infantile	1	7	8
Heart, Diseases of	45	22	67
Tetanus, Idiopathic			
" Traumatic	2	3	5
Trismus Nascentium	2	3	5
Injuries	16	16	32
Suicide	2		2
All Other Causes	93	111	204
TOTAL	420	314	734

Still-born Children—White, 22; colored, 11; total, 33.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 24.00; colored, 41.86; total, 29.36.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.06
Mean temperature	53.
Total precipitation, inches	5.46

Prevailing direction of wind, southeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LII. MAY, 1900. No. 11.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

A NOTE ON THE INTERVAL BETWEEN INFECTING AND SECONDARY CASES OF YELLOW FEVER FROM THE RECORDS OF THE YELLOW FEVER AT ORWOOD AND TAYLOR, MISS., IN 1898.

BY H. R. CARTER, M. D., U. S. M. H. S.

When a man develops yellow fever in an uninfected place, if the conditions of his environment and of the people therein are favorable, some of the people will develop the disease (See foot note No. 1.).

A proper inquiry is of the *space of time* which intervenes between the development of the first case which infected the environment and the development of the cases contracted from this environment; and it is to give some data on this subject, observed at Orwood and Taylor, Miss., in 1898, that this note is presented.

The question set by the writer is, *how long in time in every particular instance determinable at Orwood was it between the development of a case of yellow fever in an uninfected place and the development of the next case* (and other cases) *contracted* (indirectly) *from the infection from the first case?*

There are quite a number of observations in various reports and histories of epidemics of isolated instances bearing on this subject, but no great number are so observed and so recorded as to be beyond question reliable. Indeed, it is obvious that the conditions for reliable observation on this matter are not common. It is necessary:

(1). That the date be known of the development of the case of yellow fever which caused the infection of the environment, *i. e.*, of the "infecting case."

(2). That it be *known* that the cases accounted as contracted from the environment in question *were so contracted in fact*, *i. e.*, were not contracted from other sources, including fomites brought by the first sick man.

(3). That the exposure of these secondary cases be known to be practically continuous from the development of the first case.

Now yellow fever is essentially a disease of towns, and it is easy to see how rarely are we able to fulfil the first two conditions in a town of any size. If we *are* able to determine the first case near enough to its development to watch for the secondary cases (which does not always occur), we do not usually get more than one observation, *i. e.*, of the people contracting the fever in the house with the patient, the intercommunication of people in a town being such that after this it is difficult to certainly trace the source of infection of persons developing the fever.

Another difficulty is that observations are not usually made or records kept of a kind to determine the problem we are investigating, so that if the conditions are favorable for observation, the records do not properly preserve them.

The epidemic of yellow fever at Orwood, Miss., in 1898, was peculiarly well suited for observing this element in the propagation of yellow fever, and the record of it, which, by the courtesy of Drs. Gant and Mathews, of the Mississippi State Board of Health, I am permitted to use, was kept with particular reference to throwing light on this subject, as well as some others involved in it.

Orwood is not a town, or even a hamlet. It is a "Neighborhood." An agricultural community about *twelve miles* from the railroad at Taylor, consisting almost exclusively of white people, living on their farms, seldom closer than a mile apart, working their own lands with little hiring, having little intercourse with the outside world, practically all non-immune to yellow fever; intelligent, law-abiding and well disposed.

People who were at once intelligent enough to know, and honest enough to tell, the truth and to co-operate in good faith with the efforts made to trace the infection of each case and by stopping visiting, etc., to limit the spread of infection already introduced. This was rendered the easier, because Dr. Gant, who made the diagnosis of yellow fever, and under whom (directly or indirectly) all sanitary measures were conducted, was much beloved in the community, and had their entire confidence. The diagnosis of yellow fever was not disputed, although there were no deaths in Orwood until several weeks afterwards, and very few in all. A greater tribute to the good faith of the community, or to its confidence in Dr. Gant, can scarcely be given.

Yellow fever was introduced as follows:

(1) On August 6 by Miss Gray, four days from her uncle's house at Taylor, then infected, to "Gray Mansion." Miss Gray had been at Taylor four days and states that she brought no clothing with her save what she was wearing and one night wrapper.

(2) Ed. Gray, uncle to above, brought to the same house on August 25, from the same house at Taylor, where he had developed yellow fever four days before. Brought clothing in trunk, not open or unpacked up to September 3 (date of my first visit).

(3) Mrs. Gray, grandmother of Miss Gray, sickened en route from same house at Taylor to same house in Orwood, "Gray Mansion." Also on August 25 brought clothing with her, opened trunk day after arrival. All of these were sick in the "Gray Mansion."

(4) Mrs. Gray, daughter-in-law of Mrs. Gray, developed yellow fever en route from same house at Taylor to her house in Orwood neighborhood, on August 25, also. Her house was not the "Gray Mansion," but some miles from it. Brought furniture, bedding, etc., with her. Taylor is about twelve miles from Orwood, over a bad road, and normally there is not much communication between the places, mainly among the Grays.

We thus have yellow fever introduced from the outside into two houses in Orwood on August 6 and August 25. Almost certainly fomites were introduced (at both houses) on the 25th and *possibly* on the 6th; although the history, especially the subsequent history, seems to negative this.

The "Gray Mansion" was the point of spread. This house was infected prior to the arrival of Ed. Gray and Mrs. Gray in it, as is shown by the occurrence of four or five other cases there *before* their arrival. Prior to their arrival people had been visiting at the Gray Mansion. They, the Grays, were prominent people and popular in the community. After the 25th a much larger number of people came to nurse and sit up with old Mrs. Gray and Ed. Gray and the other sick. This house was virulently infected with yellow fever of mild grade. Of forty-six people non-immune to yellow fever, who were in this house on or after the 21st of August, forty-five developed yellow fever, very few having any other exposure (See foot note No. 2).

The latter part of August, the 30th, I think, the diagnosis of yellow fever was made by Dr. Gant at the Gray house and elsewhere in the community and at Taylor as well, and visiting, save such as was necessary to care for the sick (the physicians directing this), was ordered stopped and was stopped.

We thus had at Orwood:

(1) An intelligent, well-disposed community.

(2) Living almost entirely to itself in isolated farm houses, separated far beyond the aerial conveyance of yellow fever, and with very few negro houses, or other living houses on the same farm.

(3) A definite introduction of the disease.

(4) An early diagnosis, there being then but one focus active in spreading fever from which many people had contracted it to develop it later.

(5) The cessation of visiting after the announcement of the fever, except such visiting as was known to the reporter.

(6) The almost entire absence of negroes in the community, and that none of them had so far developed the disease. Infection among negroes is confessedly difficult to trace.

Obviously it presented an ideal field for the study of "house infection" and properly studied should throw light on several problems connected with this disease, among them the subject we have mentioned.

To avail ourselves of the best advantage of the situation for this purpose it was agreed at the instance of the writer to keep the records by "houses" and to scrutinize carefully the probable and possible exposures to infection of those developing yellow fever even after this knowledge ceased to be of any importance from a sanitary (preventive) standpoint.

With this preliminary let us examine the "house record" of Orwood. This was kept by Dr. Mathews under the auspices of Dr. Gant, much of the data being furnished by Dr. Gant. It has been compared with some notes (of the earlier cases) of my own and some of later cases, by Dr. von Ezdorf (U. S. M. H. S.), with which in this matter it agrees. Much pains has been taken to exclude doubtful statements, or to indicate that they are doubtful. I can not give the full weight to records of houses in which the cases appear late in the epidemic, as the source of infection is less certainly traced after many foci of infection are developed and the isolation has continued until it is irksome. Only those in the early part of the epidemic then will be relied on.

For the purpose of this paper, the records used as reliable are believed to be so (See foot note No. 3).

House I.—Gray House—Orwood.—Sallie Wilson Gray, at Dr. Gray's, in Taylor, July 29 to August 2, at 6 p. m., developed fever, August 6, 11 p. m.; Lucille Gray, room mate of above, August 23, 11 a. m.; Annie Gray, August 24, 11 a. m.; Sam Gray, August 24, 7 p. m.; Pate Gray, August 25, 2 a. m.; Cecil Gray, August 25, 12 midnight; Christobel Gray, August 25, 7 p. m.; Ed. Gray brought home from Taylor (sick August 21) on August 25; Mrs. Charles Gray, brought home from Taylor, sickened en route, August 25; Mrs. Knox, nurse, arrived August 23, 1 a. m., sickened August 31, 2 a. m.; Mrs. McCarter, nurse, arrived August 27, 2 p. m., sickened September 1, 9 a. m.

Dr. Mathews also developed fever here five days from first exposure (four days' continuous exposure), but was not treated here.

Several others, nurses and helpers, also developed fever in this house, some being treated here and some taken elsewhere. All who lived in the house developed fever there and all save one who entered it after August 21.

Here there were sixteen and one-half days between the first case and the second and five others within the next two and one-half days (see foot note No. 4).

All of the above to Edward Gray were continuous residents of this house from and before August 6.

Miss Gray denied that she brought any clothing or fabrics or anything whatever from Taylor, save the clothing she was then wearing on her person. Even had she done so we would scarcely accuse any such apparel, brought already infected from Taylor, as the probable cause of this outbreak. We would have expected her sister (and room mate) to have developed fever long before the boys, and certainly prior to the twenty-first day of the introduction of the already infected fomites. I think, then, there is little reason to ascribe the infection of these people to fomites brought infected from Taylor. Still, although improbable, this is possible, and if any one wishes on this account to exclude this case from the "infection of environment by the patient" he can do so. The fact remains that it was sixteen and one-half days between the development of the first and second cases (see foot note No. 5).

HOUSE No. 2.—MCMILLAN'S:—G. W. McMillan, August 29, 12 noon, exposed at Gray's: Mrs. McMillan, September 13; two sons of above, September 13.

McMillan claimed to have had only one exposure of some four and one-half hours at the Gray House (notes of writer) on Thursday, August 25, and brought nothing therefrom save the clothes he was wearing. He did not remove his coat at Gray's and wore it back to his own house. With this history, and as no one save himself sickened until the 13th of September (he sickened August 29) it is fair to consider him as the "infecting case" of the house.

The time interval is fifteen days (plus or minus a fraction of a day) and three people, all in the house, sickened within twenty-four hours.

HOUSE NO. 3.—PHIPPS SPEARS:—Phipps Spears sickened August 29, 1 P. M., source of infection, Gray's; Mrs. Spears, September 18; Miss Katy Spears, September 18; Miss Bertha Spears, September 19; Laura Spears, September 22.

This gives twenty days between the first and second cases, four of which developed within five days.

HOUSE NO. 4.—CROWELL'S:—I. G. Crowell, sickened September 2, exposed at Gray's.

No other cases in this house, although there were several other people living there, non-immunes. Gives no data on this subject.

HOUSE NO. 5.—TRELOAR'S:—J. C. Treloar, August 31, 10 A. M., exposed at Gray's; Mrs. Treloar, September 1, 4 P. M., exposed at Gray's; Dorothy Treloar, September 29.

After the house was disinfected, September 26 and 28, Ruth Treloar, October 2; Jack Treloar, October 11.

Here although there were two persons sick of yellow fever in the house, both contracting it at Gray's, yet no other cases developed for twenty-nine days after the occurrence of the first, and twenty-eight days after the second case, and five out of eight non-immune children resident in the house escaped fever. What influence the disinfection had on the development of the fever, I do not know; may have been simply a concomitant; or the stirring up of things, etc., in that process may have brought some fomites into activity. The late occurrence of the last case, October 11 (in a good sized boy), for reasons before mentioned, rendered it difficult to exclude infection in this case from other sources than this house. Unrestricted visiting between houses where sickness existed was resumed in the early part of October.

Taken altogether, the data record of this house is not altogether satisfactory; if considered, its interval is twenty-nine days.

HOUSE NO. 6.—W. E. Sims, August 31, night, contracted at Gray's; H. E. Sims, September 1, 2 A. M., contracted at Gray's; Mrs. Sims, September 20; Reginald Sims, September 20; James Sims, September 20; Joe Sims, September 22; Minnie Sims, September 27.

The first two cases were contracted at Gray's, and the interval to the secondary cases is twenty or nineteen days, according as which is taken as the "infecting case." Three of the secondary cases occurred in one day, and all in the house (seven) had the fever.

HOUSE NO. 7.—FISHER'S:—Rufus Fisher, exposed at Taylor, September 3; Miss Gertie Fisher, September 26; Miss Sally Jones, September 30; Miss Mollie Fisher, September 30; Mrs.

Fisher, October 2; Ruth Fisher, October 4; Dosia Fisher, October 6.

Twenty-three days here between the first and secondary cases, of which there were six, somewhat more scattering than is usual, but all within ten days.

HOUSE NO. 8.—RUFUS SPEARS:—Walter Johns, September 17, exposed at Ed. Spears'; Rufus Spears, October 8; Mrs. Spears, October 8.

Twenty-one days is the interval here. This house is probably later than should be taken, but is given by Dr. Mathews as I have recorded it.

HOUSE NO. 9.—AB. JONES:—Ab. Jones, August 31, 3:30 P. M., contracted at Gray's; Mrs. Jones, September 22, 3 A. M.; Miss Edna Jones, September 22, 4 P. M.; Earl Jones, September 22, 5 P. M.; Herbert Jones, October 5, 1 P. M.; Leslie Jones, October 20, 3 P. M.

Twenty-one and one-half days between the first and next cases, three of which occurred the same day. For reasons given before the origin of infection in the case of Leslie Jones doubtful.

HOUSE NO. 10.—MRS. ROGERS:—Mrs. Rogers, September 4, 10 A. M., probably contracted from Taylor; Miss Eva Rogers, September 20; Miss Della Rogers, September 22.

Sixteen days between first and second case.

HOUSE NO. 11.—BERRY HARRISON'S:—Berry Harrison, September 25, probably fomites from Gray House; Mrs. Harrison, October 8.

Interval is thirteen days, but there is a chance of exposure of Mrs. Harrison to fomites after September 25.—*Unreliable.*

HOUSE NO. 12.—DR. LOCKE:—Dr. Locke sickened October 1; no other cases in house.

Introduction by fomites from Taylor, second case exposed to same fomites continuously to development of fever.

HOUSE NO. 13:—Only one case in house.

HOUSE NO. 14:—Origin ascribed to fomites, exposure being more or less continuous thereto.

These three houses give no data bearing on the question we have set ourselves, nor indeed does house 11 give such that one can rely on.

House No. 15.—White:—W. N. White, September 2, 1:15 a. m., contracted Gray's; D. A. White, September 22, 2 p. m.

Twenty and one-half days interval, no record of number of people in house.

House 16.—Ragland:—Miss Pearl Ragland, August 29, 9 a. m., contracted at Gray's; J. Ragland, August 30, 12 midnight, exposed at Gray's; Miss Jane Phillips, September 9, 12 midnight.

The interval here is eleven and one-half days as the time between the development of the first and secondary cases. There were two people sick of yellow fever in this house (a small close one of one story), and as I remember, only two rooms, and there were but these three in the house when I visited. Miss Phillips, who nursed and cared for both at that time (September 4), was "anxious and overworked" (See foot note No. 6.).

House 17:—Only one case reported in the house, gives no data on this subject.

House 18.—I. B. Orr:—Langdon Orr, young man, sick August 22, 3 p. m., at Gray House on evening of August 18; Miss Maggie Orr, at Gray House, August 24 and 27, sickened August 30, 1 a. m.; Dr. Mathews brought in sick from Gray House September 3, in afternoon; I. B. Orr continuously exposed at Dr. Gray's house from August 25, sickened September 6; Miss Carrie Orr at Gray's August 25 and all night of 27, sickened September 7; James Orr, September 20; Harry Orr, September 24; Miss Bell Orr, September 27; Mrs. I. B. Orr, October 7; Lessie Orr, October 7; Miss Mary Ann Orr, October 7.

Miss Mary Orr was at the Gray House in August, and once in early September, and is the only person who visited that place after August 20, who did not develop yellow fever under such conditions that it must (most probably) be ascribed to the infection of that house. This is an extremely interesting house and my own notes on it up to and including September 4 are full. The house was a large, airy one. The family consisted of ten. They were close friends and relatives to the Grays at Orwood, and visited there although it was some miles distant. Mr. Orr and some one of the elder daughters (Maggie, Carrie and Mary) were then almost every day from the 25th on, nursing the sick, etc. Mrs. Orr, having many household cares, and the younger children did not go. The whole family had fever. Visiting stopped when Mr. I. B. sickened, there being then four sick with fever in the house, and all who could help were needed at home. Whether Maggie Orr, Mr. Orr and Carrie Orr contracted fever from Gray's or from their own environment infected by Langdon Orr, may be a question. The writer believes that enough is known to decide in the case of the first, but it is not the purpose of this paper to use cases as secondary which may have contracted the disease elsewhere, or vice versa. It will be discussed later on.

An interval between the infecting case and the first case contracted from the infected environment can not be determined for this house.

House No. 19.—J. W. Gray:—Gives no data determinative for this subject.

House 20.—Dr. Gray:—Gives no data useful for this subject.

Taylor, Miss.—Records of the same kind, by houses, were made of the cases at Taylor, but the conditions were far less favorable.

(1) The place was almost a hamlet, some of the houses being close enough for aerial transmission of infection between them, with a common loafing place in the railroad depot and the store. The depot was infected early; whether the store was we did not determine.

(2) The fever existed quite a while, six weeks at least, before it was diagnosed, and several (four or five) foci of infection had been formed, and nearly or quite a dozen cases had occurred.

(3) There was a considerable negro population, thickly settled and mixed with the whites, of whose visiting and conveyance of fomites no one can predicate. The presence of this race introduces an element of uncertainty in tracing the propagation of yellow fever that it is difficult to overestimate.

(4) Some of the notes taken at Taylor were necessarily taken some time after the occurrences to which they refer, and thus there is question about dates and (I think) sometimes of diagnosis. There are a few houses at Taylor of which the records are definite and correct; the date being either the date of record (by Dr. Haralson or myself) or so fixed by record (of deaths, etc.) that they can be relied on. I give them:

I. House of Rev. Mr. Williams:—Twelve in family. House very clean and well kept. Isolated from others. Two colored servants.

Hampton, August 7, at night, eldest son; believed to have been exposed at Dr. Gray's. Died, with suppression and black vomit, turning very yellow, August 10. Both this death and Dr. Gray's were ascribed to "Congestion;" Grover (age 12), August 27, at night; Mrs. Williams, September 3, 8 A. M.,; Ora (24), September 4, 12 night; Lee (22), September 6, 9 A. M.,; Mark (9), September 8, at night; Sidney (17), September 9, 9 A. M.; Viva (3½), September 9, 10 A. M.; Susan Thomas (colored), September 9, during the night; Cleveland (6), September 10, at night: Nettie (26), September 15, 4 P. M.; Charles (15), September 19, 11 A. M.,: Mr. Williams, September 23, 4 to 5 A. M.; Laura Spicer (col.) September 23.

Twenty days is the interval here between the first (infecting) and secondary cases. The secondary cases, thirteen in all, followed in fairly rapid succession after they began. The children were kept out of the house as much as possible, and slept upstairs as far as possible from the sick rooms (until the latter became too numerous to be avoided) for the purpose (and we believed with the result) of delaying some of the attacks, so that all might not get sick at once. An explosion—several cases in one day—is not an uncommon occurrence in large households.

II. THE SISK HOUSES, 11 inmates:—"Two houses, 30 to 40 feet apart, practically one so far as communication is concerned until the development of fever in Mr. Jesse Sisk, communication of adults continued free after that date, Lewis Sisk and wife nursing the people in the other house. That of the children was attempted to be prevented but they go to their grandparents constantly, especially after the development of their mother's case:"

"*Jesse Sisk's*, 4 in family."—Walter Morrison, August 17, probably from Dr. Gray's; Will Sisk, September 2, night; Jesse Sisk, September 5, night; Mrs. Sisk, September 6, night.

"*Lewis Sisk's*, 6 in family and 1 colored."—Mrs. Sisk, September 7, 4 P. M.; Lewis Sisk, September 8, 10 A. M. (may have contracted this disease elsewhere); Henry Sisk (baby), September 8, 12 midnight; Sue Joiner (colored), September 12; Rodney, September 13, 10 A. M.; Charles, September 17, 1 P. M.; Paul (10), September 23, 5 P. M. (See foot note No. 7).

Sixteen days is the interval given here. The secondary cases, nine in fifteen days or ten in twenty-one days, follow somewhat more slowly than we have seen. The children were not continuously exposed to their grandparents' house. Will Sisk was an invalid, with surgical kidney.

HOUSE III.—(Taylor Hotel).—Five in family; Captain Taylor, August 10, 4 P. M., at Dr. Gray's; Mrs. Taylor, August 11, 11 A. M., at Dr. Gray's; Clarence (colored), August 25; Guy Taylor, August 28; Mrs. Guy Taylor, September 5.

Clarence went almost everywhere and may have contracted his disease elsewhere. Fifteen days is the interval to Clarence (18 if he be held doubtful).

There are other houses recorded in the Taylor "House Record" which could be taken as probably satisfactory, but they are not certainly so. The three we have given we believe do fulfil the conditions laid down.

Grouping the results obtained, we have the following summary:

SUMMARY FOR ORWOOD AND TAYLOR.

House.	Infecting Case.	First Secondary Case.	Interval in Days.	Secondary Cases.		People in House.	Remarks.
				Number	Days.		
Orwood 1	Aug. 6	Aug. 23	16½	6	2½	(*) 7	Of 46 persons exposed, 45 probably contracted fever here.
2	Aug. 29	Sept. 13	15	3	1	(*) 4	
3	Aug. 29	Sept. 13	20	4	5	(*) 5	
6	Aug. 31 or Sept. 1	Sept. 20	19½	5	7	7	3 secondary cases occurred in 1 (the first) day.
7	Sept. 3	Sept. 26	23	6	10	(?)	
9	Aug. 31	Sept. 22	21½	4 or 5	13 or 28	6	Source of infection in last case doubtful.
10	Sept. 4	Sept. 20	16	2	2	(?)	
15	Sept. 2	Sept. 22	20½	1	....	(?)	
16	Aug. 29 Aug. 30	Sept. 9	11½	1	....	3	Shortest interval of the list.
Taylor 1	Aug. 7	Aug. 27	20	13	27	14	Secondary case developed in 14 days.
2	Aug. 17	Sept. 2	16	8 or 9	15	10	Paul Sisk is not rated as contracting fever at Jesse Sisk's.
3	Aug. 10 Aug. 11	Aug. 25 Aug. 28	15 or 18	3 or 2	11 or 8	5	

* All continuously resident.

The "intervals" for the twelve houses run fairly uniformly mainly from 2 to 3 weeks, one house giving less than two weeks (11½ days) and two houses more than three—21½ and 23 days respectively.

The temptation to quote instances observed elsewhere; to collate them with the result given above and to attempt to formulate the usual inferior limit (see foot note No. 8), for the time between the infecting and secondary cases is considerable, but this note was intended to give the interval of time which *did* elapse in all the houses at Orwood and Taylor between the first case of yellow fever and those believed with reasonable certainty to have developed yellow fever from infection brought to the house by the first case.

This ends our note, but it is judged best to give an appendix of the records of *all* the houses in Orwood (although some give no determinative information on this subject). The reader can judge for himself whether there was any improper selection of houses; if any were omitted which should have been taken in the foregoing table or taken which should have been omitted. For Taylor this is not possible, some of the data being not only indeterminate but unreliable. Those given for Taylor are all of which the writer has satisfactory record and which he believes to fulfil the required conditions.

Foot Notes.—No. 1. It is assumed that the infection of yellow fever may be conveyed directly from one sick of that disease to his environment, it being so generally admitted that it seems a waste of time to argue it; but the data recorded in this paper do not depend on or involve this theory or indeed any theory. They are simply facts that were observed.

No. 2. This house was a frame house, old, but sound and well preserved, on the top of a considerable hill, well exposed to sun and wind, and, as far as I could judge, as clean and the premises as well kept as country houses of the better class usually are; although at the time I saw it, there being then seven cases of yellow fever in it, and one very ill, it was probably less well cared for than usual. The privy was distant from the house, and clean. I did not, however, give the place a close sanitary examination.

No. 3. Far more important than to determine the time between infecting case and secondary cases (or the inferior limit of this time) is to determine the limits of the period of incubation of yellow fever in one contracting it and the period of "house infection" or so-called extrinsic incubation (which of course are involved in the problem set ourselves). It will be recognized that the conditions at Orwood, and to a less degree at Taylor, were extremely well suited for the study of the former problems, and indeed the observations there are for this purpose extremely valuable; but as the writer has been collecting data on this subject since 1887, it seems better to collate these (Orwood and Taylor) observations with the others when time and convenience permit the work receiving the care it deserves.

No. 4. Langdon Orr, who very probably (almost certainly) contracted his sickness from this house, was also sick at this time. (See House No. 18). He sickened August 22. To him the "interval" would be 16 days. Note that he developed the fever before Miss Lucille.

No. 5. When the source of infection of a household is fomites, we generally observe several cases developing about the same time, without the long interval between the first and other cases. Of course, the times of exposure to the fomites of different members of the household and individual susceptibility may be such as to make any variation in the dates of development. The statement, however, is *generally* true.

No. 6. Compare with a case at Jackson, Miss., 1899: "Mr. H. developed yellow fever October 20, in early morning; Mrs. H. developed yellow fever October 30, at night. Interval 10½ days."

No other non-immunes in the house, children having been sent away. Mrs. H. did not leave the premises, scarcely the sick room and the one adjacent, from the date Mr. H. became sick. Mr. H. was exceedingly ill and Mrs. H. was under severe strain, moral and physical. He was treated on the ground floor and the room was kept dark, the weather being intensely hot. Mrs. H. slept (when she slept) in adjoining and communicating room. No attempt at sanitary precautions in the house. Mrs. H. was from mountainous district in Virginia.

We might (from analogy) consider that the conditions here and at Ragland were favorable for an early infection of the premises and for lowered resistance of the one exposed, and thus (with the intimate exposure) favor an early development of the secondary case, and thus explain the fact that these two "intervals" are shorter than usually observed. The writer is not inclined, however, to offer any explanation; the conditions which affect house infection and individual susceptibility are not sufficiently known to theorize on them.

No. 7. Up to September 10, and doubtless afterward, this boy (age 10) was being kept away from his grand-parents' premises, where all were very ill (two of them dying), to keep from disturbing them. He most probably contracted his fever at home, from Lewis Sisk's premises.

No. 8. Obviously only the inferior limit is in question. A place may be infected and a person live in it an indefinite time without contracting yellow fever, the time depending on individual susceptibility (temporary or permanent) and other causes.

Individual susceptibility is a factor as well in determining the time of development of the first secondary case, and thus in determining our "interval." But where there are many who develop yellow fever in a house (as at Gray's and Williams') its influence is lessened. It is not reasonable to suppose the individual susceptibility of every one of a considerable number of people, developing yellow fever, to be less (or much less) than the normal.

Appendix I.

Houses in Orwood not considered as giving data suitable for subject of this note.

House 4, Crowell's, in which no cases developed following the first case, September 2, although there were several (certainly 3) non-immunes resident there. Has been mentioned.

House 5, Treloar's, ten in family, has also been discussed at length. It would probably be honest to count this house as giving an "interval" of twenty-nine days.

House 11, Berry Harrison's, number in family (?) Berry Harrison sickened September 25. Father spent evening at Gray place August 27, and hung the clothes he wore in a closet with some feather beds. Closet was not opened until a few days before Berry was taken sick. On September 14 Berry bought sugar and pair of shoes at Tatum's store, then supposed to be infected.

Mrs. Harrison sickened October 3. *If* the first case contracted the disease in the manner implied by the reporter (one does not know enough of the circumstances to form any conclusions), the second case may well have been exposed to the same source of infection at any time from opening of the closet to date of her sickness.

The record of this house then gives nothing determinative for our subject.

House No. 12, Tatum's store: Mr. Tatum bought goods from Taylor's depot, August 24 and August 29; Mrs. Tatum, sick September 29; Mr. Tatum, sick October 4; Eva Tatum, sick October 13.

Whether the infection was introduced in the way stated may be a question; it is possible. If so who can say if the other cases were from exposure to the Taylor fomites (or other fomites) or to infection of the house of the first case?

House No. 13, J. S. Locke: Dr. Locke, October 1, exposed at Fishers. No other cases.

House No. 14.—J. T. Reeves: J. T. Reeves, sick October 5, without other known exposure than possibly the following: A shaggy house dog went back and forth from Phipps Spears' house (House No. 3) to Reeves' house and slept on chairs, beds, etc., at both places. Phipps Spears went to Reeves' house September 14 and talked with him but did not go in; J. T. Reeves, October 5; Mrs. Reeves, October 5; Clarence Reeves, October 8; Alice Reeves, October 15; Earnest Reeves, October 16.

Without discussing the etiology, which, if somewhat startling, is probable enough, there being no evidence to show that the first cases contracted the disease elsewhere save from fomites in their own house; it would be impossible to determine if the others were in a true sense secondary cases to the first.

The picture of the infection is certainly that of infection by fomites, or at least common infection for all. Notice the lack of considerable interval. Independent of history it is too late in season to be used.

House 17.—Dennis Caruthers, exposed in Gray House, sickened September 10th, 2 A. M., no record of any other cases in his house, but no statement that there was none other.

House 19.—J. W. Gray's: Miss Blanche Gray, August 27. Contracted at Dr. Gray's. House disinfected September 18. Subsequently no one was permitted to go in or out except the fumigators, who boarded there and went back and forth from Dr. von Ezdorf's tent, 40 yards distant, who sickened (with yellow fever) September 27, and was there treated.

J. W. Gray, October 8, 1 P. M.; N. D. Gray, October 9, 10 A. M.; Pat Gray, October 10, 8 A. M.; Mrs. J. W. Gray, October 14, 2 A. M.; Robert Gray, October 18, 11 A. M." (Mathews' notes.)

Without discussing the probable source of infection of the last five persons, it is obvious that considering the lateness of the season, and consequent general diffusion of the disease in the neighborhood, the presence of the "fumigators"; the existence of a case of yellow fever within forty yards; together with the impossibility of preventing five people, four of them men and boys, from going out for three weeks, we can not be satisfied that they were infected from the environment infected by Miss Blanche Gray; if the disinfection was efficient it certainly was not.

This house, then, gives us no data which we can use for the subject in hand. The probability is that this house escaped infection from the first case, and that either fomites were introduced prior to October 8, or that the last five cases were exposed to a common extraneous source of infection. The picture would be the same in each case, and would correspond with what we have.

House No. 20—Mrs. Dr. Gray's: Mrs. Dr. Gray sickened on the road from Taylor, 10 A. M., August 25. All her children, three in number, had been sick at Taylor. There were naturally no cases at this house. The moving was general, her bedding, furniture, etc , coming also. No infection in Orwood is ascribed to this house.*

APPENDIX II.

House No. 18, Orwood. We propose to further discuss the propagation of yellow fever at house No. 18, Mrs. Orr's:

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*If my recollection be correct, this house was close to house No. 19, and Mr. J. W. Gray and his sons attended to the comfort of this family and their affairs generally, and I had suspected, although I have no direct evidence, that the infection of this household in October was from this source. It is difficult to be careful for a long time, especially when few died.

Note that all those who sickened before September 20, had been exposed at the Gray House, a badly infected place; that none of those who had not been there exposed (at the Gray House), sickness prior to September 20.

Note also the considerable interval, thirteen days, between the development of the last case exposed at the Gray House and the first case not so exposed, and that the intervals between the cases known to be contracted from infection at Orr's house is much less.

From this alone I think we would be justified in saying that it is most probable that the cases arising prior to the 20th were contracted at the Gray House, and those from that date at Orr's. Orr's house being infected by some of the preceding cases.

If, in addition to this, we compare this house with all the others we have recorded, we find that none of them show so short a time as seven and a half days between the infecting and secondary cases, and unless Maggie Orr's case was to that extent exceptional, it was not a secondary case, and therefore not contracted from infection of this residence by Langdon Orr.

The same can not be said of the next two cases, 15 and 16 days respectively from the first. There are intervals which we have observed. The intervals of development September 6, 7, 20, 24 and 27 of the whole group do not correspond with what we have seen of secondary cases in other Orwood houses. While the group from the 20th on does so correspond.

The conclusion the writer would reach is that Miss Maggie Orr contracted her fever at Gray's; that it is highly probable that Mr. Orr and Miss Carrie Orr did also, and that only the cases from the 20th on were contracted from the infection of Orr's house; infected by some (it need not have been Langdon) of those who were sick in it.

APPENDIX III.

Obiter Dictum.—Broadly the question to be considered, and to which the data in the preceding paper may be contributory is this: *Is the time between the development of the case which infects its environment and the next other cases contracted therefrom* (i. e. from the environment) *usually so definite that a general statement of the limits of this time can be made?*

So far as the writer knows this (general) subject is not discussed in any systematic treatise on yellow fever, yet it is alluded to in several brochures and is now recognized (at least as a general working hypothesis) by many who have observed the spread of yellow fever in places where it is not endemic.*

The time from the infecting to a secondary case obviously consists of three periods:

(1) The time from the development of the infecting case to the time the environment is capable of developing infection in other men, plus

(2) Time the individual in question is exposed to the environment before he contracts the disease, plus

(3) Time from the date of contracting the disease to its development in him.

In the general case all three are variants and, while this "time" includes all three, by itself it would give us little chance of determining any one of them. It may, however, be made a factor in that determination if we have other data.

It is exceedingly desirable from a practical standpoint to determine the limits of the "period of incubation" of yellow fever and it was on this subject that the writer was engaged (since 1887), when he was impressed with the general uniformity of time interval between first and secondary cases in a number (5) of instances. Inquiry of more experienced observers showed that the phenomenon had been observed by others, and while further observation and inquiry showed that the uniformity first observed (16 to 18 days) was accidental and closer than was generally found, yet there is much evidence to show that it is usually "in the third week" (Jno. Wall of Tampa), or better, "usually *not prior to the third week*" that secondary cases develop.

It is the belief that the secondary cases follow immediately on the infecting case that causes the laity to doubt (generally to deny) the diagnosis of yellow fever, "because it has been ten days and no case has developed among the family."

The sanitarian can not take this comfort to his soul (it would be a comfort to him were he the discredited diagnostician him-

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*Maximilian Corre, who does not believe that a man sick of yellow fever can infect his environment, *regarding the disease as a toxemia, not an infection*, probably has something on this subject, as there is an allusion to a subject involved in the "Extrinsic Incubation" of yellow fever in one of his lesser works. The writer has been unable to see the work alluded to (also one of Corre's) and at present has access only to his own notes.

self), or that which springs from the hope that the case did not infect its surroundings until a much longer time has elapsed. There is, of course, no definite limit of time at which we would call the situation "safe," or "unsafe," but hope of safety increases with the passage of the third week, and as the time beyond this passes.

This law (one will admit it at least as a working hypothesis) is also of value in predicting the progress of an epidemic which will spread. From the first (infecting) case to the first group of cases, infected at his house, is generally from two to three weeks. These form new foci (the original one remaining active), and in from two to three weeks more the second group of cases appears. At this time, four to six weeks, the fever should be "scattered" in tertiary foci, just beginning. Prior to this it is found *only in those who have had a common exposure*, seldom then in more than four to eight places, although it is not the number, but the common exposure, that is in question.

CLINICAL OBSERVATIONS ON HEROIN AND HEROIN HYDROCHLORIDE, AS COMPARED WITH CODEIN AND MORPHIN,

By Dr. F. C. Floeckinger, La Grange, Texas.

Among the narcotic alkaloids, opium and its derivatives occupy incontestably the first place. Of the 17 alkaloids and the other allied combinations which have no decided basic properties, morphin and codein are chiefly employed in medical practice and have become indispensable to the physician.

Aside from the after-effects of morphin, such as nausea, general lassitude, vomiting and vertigo, this preparation has the disadvantage that the patient becomes readily addicted to it, and chronic morphinomania occurs especially in neurotic persons. This is less common in Germany and Austria where the sale of morphin is under the control of the State than in the United States where no such monopoly exists.

Codein in its physiologic action resembles narcotin, but the narcotic stage is not so much pronounced. When administered in small doses intestinal peristalsis is promoted, while in large doses it produces diarrhea in consequence of complete relaxation of the intestinal muscles, owing to paralysis of the nerve centers governing the intestine. E. Grimaux, as early as 1881, was able to demonstrate that codein is a methyl ether of morphin, and succeeded in artificially preparing codein from morphin. By substitution of alcoholic radicals an entire series of artificial bases (codein) can be prepared. In France codein was first introduced as a substitute for morphin, but statistics show that its therapeutic action is very irregular, and in many cases no physiologico-therapeutic results could be observed. Experiments showed that this variable effect is attributable to the degree of purity of the preparation. Furthermore, the effect of codein is 6 to 8 times weaker than that of morphin. Its action in general is milder, less narcotic, and the vascular system is less stimulated. The salts of codein (codein hydrochlorate, codein sulphate, etc.) act more intensely, and these combinations have been mostly employed in practice. In the troublesome cough of phthisis, in chronic bronchitis, insomnia, ovarialgia, enteralgia, without any pathologico-anatomic origin, codein is extensively used as an anodyne. It is generally known that codein is less toxic and dangerous than morphin. On the other hand, its narcotic and sedative action is unreliable, and the intense pains of cholelithiasis, nephrolithiasis, etc., are often not alleviated by large doses, so that a physician is compelled in the end to resort to morphin. When Professor Dreser, therefore, reported on the physiologic action of a new morphin derivative, named heroin, which was intended to displace both morphin and codein, it was a source of great satisfaction.

Heroin is the di-acetic-acid-ester of morphin, and is prepared from the latter by the substitution of acetic ester for two atoms of hydroxyl. The question which we desire to elucidate here is whether heroin has a sufficient sedative action to compete with morphin and codein without the disadvantages of the two latter remedies. As above mentioned, codein does not act intensely enough as a sedative or narcotic in many painful affections unless it is used in large doses, which are often followed by toxic phenomena. Morphin is an excellent analgesic, but in chronic maladies its prolonged use may give rise to deleterious effects upon the organism. Furthermore, there are persons who have a certain idiosyncrasy towards morphin, and who, in place of the desired sedative effect, experience an exaltation of the entire nervous system. Moreover, cases are recorded in literature in which even after the use of minimum doses toxic phenomena have occurred.

Accurate studies of the effects of heroin as compared with those of morphin and codein have been undertaken especially with a view of determining its sedative action in acute affections of the respiratory tract, and less for the purpose of establishing its narcotic action in painful affections. This question has been most conscientiously solved by Prof. Dreser by means of experiments on animals, and later by observations on human beings. Let us for example take a case of chronic bronchitis attended with violent cough, for the relief of which morphin is ordered. The patient is apt to become so accustomed to the drug that after awhile he is unable to get along without it; and secondly, expectoration is not promoted by morphin, and during its continued use no complete recovery can occur. Dreser and Floret call attention to the excellent effect of heroin as a sedative in coughs. Experiments made by Dreser on animals showed that ten times as much heroin as codein is required to produce toxic effects. Furthermore, ten times more by weight of codein than heroin was required to produce the desired slowing of the respiration. The experiments which I undertook showed that after comparative doses of heroin and codein the latter produced nausea, vomiting and vertigo, while these symptoms were absent during the administration of the former.

The next investigations made by Dreser were intended to show whether heroin has a sedative action upon the respiratory organs. To judge from his observations, however, this is not the case, since heroin acts as a sedative upon the cough center, while upon the respiratory center it acts as a stimulant. This is a point of great importance, as it enables us to employ the remedy in old, decrepit persons, or those who have been exhausted by protracted acute disease,and without the risk that in consequence of paralysis of the respiratory centres and the accompanying stagnation of the secretions pulmonary paralysis might occur. In this connection I would mention a case in the practice of one of our resident physicians here, which can not fail to prove of interest. The patient was a farmer's wife in her thirtieth year, who suffered with acute pulmonary lobar pneumonia; she was restless and sleepless, and requested the physician to give her some morphin. The request was complied with, and she received one-fourth grain morphin sulphate per os, which was repeated in an hour. This was in the evening. After the administration of the second dose the patient fell asleep, and five minutes later death occurred in consequence of pulmonary paralysis. We see, therefore, that great caution must be exercised in the administration of morphin in acute diseases of the lungs owing to the liability to pulmonary paralysis. As heroin, however, acts as a stimulant to the respiratory center, stagnation of the secretions is excluded. From this we see that the action of heroin is diametrically opposite to that of morphin. Heroin diminishes the frequency of respiration especially by prolonging the inspiration, and by stimulating the respiratory center it increases the force of inspiration and expiration. In consequence of the prolonged inspiration a larger quantity of air is taken up by the lungs, while expiration takes place more forcibly, and owing to this the secretions are more readily expelled. Right here I would remark that the narcotic effect of heroin in general is inferior to that of morphin, and this applies also to codein.

I have employed heroin quite frequently in my practice during the last year, and as physician to the County Hospital, Poorhouse, the Asylum and County Jail, I have had an opportunity to give it an extensive trial in various pathologic conditions. I have used it in various acute affections of the respiratory tract, comprising lobar and lobular pneumonia, acute and subacute bronchitis, pleuritis sicca, and pleuritis exudativa, laryngitis, and the respiratory complications of acute infectious diseases, such as scarlet fever, measles, typhus and typhoid fever. It would lead me too far if I were to describe *in extenso* all my cases, and I therefore will content myself with recording in brief my observations.

At the beginning I administered heroin in doses of one-sixth grain, and noted in several cases gastric disturbance, as well as vertigo. In a case of severe typhoid, vomiting and somnolence appeared after the use of one-sixth grain. Since that time I have administered heroin only in one-twelfth grain doses, repeated more frequently, if necessary. In none of my later cases were gastric disturbances observed which could be attributed to the use of too large doses. The breathing became deeper, the frequency was diminished, and the expectoration facilitated. In general, however, it took four days before the secretion became looser and the sputa more abundant. In some instances of acute bronchitis a copious expectoration occurred two days after the administration of heroin, and on the third day recovery commonly took place. From this it will be seen that in cases of so-called colds heroin acts better than the coal tar preparations, which generally have a direct influence upon the heart. In colds, however, it is advisable to give a strong laxative in order to cleanse the gastro-intestinal tract of toxic products, and also because heroin is slightly constipating, as my experience shows. From the literature that has been published up to date it appears that no unanimity prevails regarding this point. I would remark that I have treated more than 100 cases with heroin, and have always noticed a tendency to constipation. In cases of simple colds, attended with pains in the back and limbs, heroin was prescribed in the following combination:

Heroin hydrochloride	1-12 grain
Salophen	10 grains
Sacchar. alb	3 grains

M. F. Pulv. div. in dos. tal. No. xv.
Sig: One powder every two hours.

In all cases treated with this combination successful results were obtained in a very short time.

In acute pleurisy and acute pneumonia with violent pains in the side I was unable to obtain the desired effect from the administration of heroin per os. It required a considerable time before alleviation of the symptoms took place, and hence I employed heroin generally hypodermatically, with excellent results. Heroin in a solution of acetic acid does not constitute a good injection fluid, and hence I made use of the hydrochloride. This preparation, which been thoroughly investigated by Professor Eulenburg, of Berlin, is admirably adapted for hypodermatic application. It is very soluble in cold water, and is readily absorbed. Abscess formation failed to occur in any of my cases, and should it take place must be attributed to faulty technique. It is necessary that the place of injection should be first thoroughly disinfected, and if an antiseptic for this purpose is not at hand soap and warm water should be used. The fluid should be slowly injected, as otherwise the injection is painful. To render the insertion of the needle painless chloride of ethyl spray may be employed. After the injection I close the puncture with iodoform collodion. I usually injected one-twenty-fourth grain into the subcutaneous tissue, and in 96 per cent. of all the cases relief occurred after a few minutes. This occasionally lasted for two hours, and the patients requested me to make another injection when a fresh attack of pain occurred. After injections of one-twenty-fourth grain no lassitude was observed, such as is noticed after the administration of morphin. Injections of one-twelfth grain were well tolerated, but some patients complained in regard to the resulting relaxation. This occurrence, however, is of no significance, and no other symptoms appeared.

In my experiments I further observed that if after injection of one-twenty-fourth grain of heroin hydrochloride the third or fourth dose was increased successively to one-twelfth grain no lassitude occurred. On the other hand, if an initial dose of one-twelfth grain was injected subcutaneously, lassitude ensued in all my cases, and this often lasted for an hour. After the second injection, however, this feeling was less pronounced, and after the fourth and fifth was entirely absent. I believe that we are warranted in concluding from this experiment that a certain reaction does take place in the central nervous system owing to the influence of the drug upon the nerve cells. Now it might be claimed that in consequence of this action an habituation to the drug might take place. In regard to this I would remark as follows: In the employment of morphin in most instances a decided narcotic state ensues which is followed by psychic phenomena of irritation. On the other hand, this narcotic stage is very slightly developed during the use of heroin and heroin hydrochloride. Inasmuch as the latter two are devoid of this narcotic action any habituation to them is completely excluded, since a morphinist would not derive the desired reaction from their use that he obtains from morphin. The most pronounced physiologic action of heroin is sedative, while its narcotic influence leaves much to be desired.

In some cases of pleuritis sicca and exudativa, gastric disturbances occurred after the administration of heroin with aspirin. Inasmuch as pathologic conditions of the gastric secretion were not demonstrable I discontinued the preparation, and after the disappearance of the stomach disturbances I resumed the administration of the aspirin alone. The gastric disorders failed to occur, and I again combined heroin with aspirin, with the result that once more they reappeared. I now administered heroin hydrochloride in combination with aspirin, and to my surprise the disturbances remained absent. For a further test I employed aspirin per os and heroin hydrochloride subcutaneously in these cases without affecting the stomach. The disorders referred to consisted in pressure in the epigastrium and nausea, but not vomiting. At this time I received a copy of the *Deutsche Medical Wochenschrift*, No. 12, containing an article by Professor Eulenburg, of Berlin, on heroin hydrochloride in medical practice, which confirmed my experience.

Professor Eulenburg writes as follows: "Chemical experiments demonstrate that heroin hydrochloride is not decomposed by the hydrochloric acid in the stomach into acetic acid and morphin. As the preparation is not split up in the stomach gastric disturbances are completely excluded, and hence this preparation is preferable to heroin." Since this time I have employed heroin hydrochloride in all instances, and I have been unable to note any disturbances of the gastro-intestinal canal.

In cases in which an accumulation of fluid in the pleural sac provoked violent pains in the side, the employment of heroin either per os or hypodermatically did not allay this symptom and aspiration was required. After the evacuation of the exudates relief occurred in all the cases, as the preparation was then able to exert its effect.

The dose of heroin hydrochloride per os is the same as that employed subcutaneously—namely, one twenty-fourth to one-twelfth grain. Some authors employ doses up to one-sixth grain. I have not found it necessary, however, to give as large a dose, since gradually increasing and more frequently repeated doses will produce the same effect. The experience of all observers goes to show that in all instances the dose of heroin hydrochloride should be less than of morphin; while codein must be given in larger dose than morphin to obtain the desired sedative effect. As regards the advantages of hypodermatic injections of heroin over its internal use, I would say that dyspnea is more rapidly influenced, and comparative relief ensues after a few minutes, while when administered per os the physiologic action of the drug is retarded, as its absorption in the gastro-intestinal tract takes place more slowly. In many cases several doses are required before any action can be observed.

In pediatric practice especially, the hypodermatic use of heroin hydrochloride is most advantageous. I have employed it here with excellent results. The administration of heroin in solution with acetic acid often provoked gastric disturbances, especially in nurslings, so that I had to abstain from the administration of the drug in this solution. After the introduction of heroin hydrochloride I made use of this preparation in watery solutions, and must say that I have yet to see a case in which gastric disorder took place. The single dose in children varies according to the age, but I would advise that it should not exceed one-twelfth grain in children under ten years, the best way is to begin with small doses and gradually increase. In general I would coincide with Professor Eulenburg's view that in adults the daily dose of one-half grain should not be exceeded.

In the county jail of La Grange, Texas, six cases of acute laryngitis have been treated by me with heroin hydrochloride. The internal administration of the drug was not attended with marked success, and I tentatively employed hypodermatic injections. The subcutaneous use gave better results, but they were not sufficient to produce complete analgesia. In all these cases I also experimented with hypodermatic injections of morphin, and must say that they were more efficient than those of heroin hydrochloride.

As regards the results obtained from the employment of heroin hydrochloride in cases of trigeminal neuralgia, sciatica, intercostal neuralgia, and various myalgias, I would say that its narcotic effect is far inferior to that of morphin. In some instances I observed successful results, while in the majority the drug proved inefficient. In neurotic persons its action was better than in the vigorous. There is, however, another class of cases which is favorably influenced by the internal administration of heroin, namely, diseases of the respiratory tract in which the main sympton is dyspnea. Experiments by Dreser on animals have demonstrated that heroin prolongs respiration and diminishes its frequency, and that owing to the increased volume of inhaled air a better gaseous exchange takes place in the air cells; and hence an improvement in breathing. He showed that the employment of 0.001 gram of heroin produces a slowing of the respiration equivalent to that produced by 0.01 gram of codein. After the administration of heroin Dreser was able to observe the influence of the drug upon the respiration with the naked eye; and my own experiments on animals give the same results. After the injection of heroin a relaxation of all the muscles occurs which lasts up to four hours. If some favorite food was placed before the animal it would not get up of its own accord, but only under constraint. The animal hastily swallowed the food in order to quickly lie down again and fall into a drowsy state. Under continued daily injections this relaxation, however, disappeared completely, and the animal remained in the same condition before as after the injection, provided the dose was not increased. If the dose was, however, increased to three-tenths grain drowsiness ensued. This did not last very long, and in one animal disappeared after eight minutes. If the increased dose was continued for some time the animal became habituated.

From these experiments it will be seen that habituation to the preparation would take place if its narcotic effect was equivalent to that of morphin, but as its narcotic effect is much inferior, addiction to heroin can scarcely be possible. Further observations will elucidate this subject in the future.

In chronic bronchitis the preparation is very serviceable; the expectoration is facilitated and the dyspnea diminished, owing to the fact that the air enters more completely into the alveoli in consequence of the increased inspiratory force. In his article in the *Deutsche Med. Wochenschrift*, No. 12, 1899, Professor Leo justly compares the physiologic action of heroin upon the respiration to that of digitalis upon the cardiac action.

I tried heroin in three patients with dyspnea, due to uremia and organic diseases of the heart. It was administered in doses of one-twelfth grain. After the third dose of this size the dyspnea improved, and at the end of the sixth day I was again able to reduce the dose. The object of diminishing the dose was twofold; in the first place, in order to determine whether the reduced dose would exert any effect upon the disease; and second, in order to reduce the cost as the patients were all maintained by the county. I diminished the dose to one-twenty-fourth grain every two hours, and after a few days I administered it only three times daily, and with good results. In not a single case was it found necessary to again increase the dose. Right here, however, I would remark that the effect was only a palliative one, and not in the least curative. The sole object was to afford the patient relief. Cases of chronic bronchitis without decided emphysema were most favorably influenced by heroin. In a few instances I was able to even obtain a cure. Of course, hydrotherapy was also resorted to. In three cases of chronic bronchitis I found that the combination of heroin with potassium iodide proved very serviceable, and here I was able to secure complete recovery. Among these cases there was one of an old man who had suffered for fourteen years from chronic bronchitis without emphysema and had consulted a large number of physicians without avail. By way of experiment I placed the patient under treatment, and after four months he was relieved of all his disturbances. In cases of marked emphysema my results were not good. I resorted to the subcutaneous method, but without any better effect. Of course, I would not assert that in these cases that heroin is ineffective, since my experience in this class of diseases is insufficient, and my sole aim in making this statement is to make my report as complete as possible.

In bronchial asthma heroin proved efficient, the patients being able to sleep in the recumbent position as early as the second day. As regards the attack itself, however, the preparation was useless, being unable to shorten or interrupt it. On the other hand, during its administration, the attacks were not so violent and the patients felt easier than usual. In two instances of reflex cough and hysteria heroin failed to exert the least influence.

The distressing cough of phthisis was influenced by the administration of heroin, although the results in the last stage were not so encouraging as in the first. In 14 per cent. of the patients I was able to demonstrate only a slight alleviation of the irritating cough. All these were cases in which a physical examination revealed the presence of cavities. In phthisis in the last stage I would advise that the dose of one-twelfth grain should not be exceeded, as I have frequently observed nausea and vomiting from larger doses. The night sweats were not affected in any of my patients by the administration of heroin, and hence I am unable to come to any conclusion as to the physiologic action of the drug in this direction.

Before closing my article I would call attention to the antipyretic action of heroin. Professor Dreser in his experiments on animals showed that during the administration of the drug the elimination of carbonic acid was reduced by one-fifth of the normal quantity. In consequence of the retardation of the metabolic process a temporary apyrexia occurs. He reports that in some instances the temperature fell to the extent of 0.5 to 1.05 deg. I was likewise able to demonstrate a reduction of the temperature in acute pneumonic troubles, but in no instance did the temperature fall more than one degree. I am therefore unable to recommend the preparation as an antipyretic, as it is not sufficiently powerful for this purpose. The circulation as well as the cardiac action are absolutely uninfluenced by heroin, and the lethal doses injected into animals produced death through pulmonary paralysis.

Briefly summarizing my experience, I would say that we possess in heroin an excellent sedative for the respiratory tract, which is devoid of the narcotic effect of morphin and codein, and therefore in physiologic doses is entirely uninjurious.

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Clinical Lectures.

[Specially reported for the JOURNAL from the Philadelphia Clinics.]

I. UNDIAGNOSTICATED ELBOW INJURY. II. MOVABLE KIDNEY.

BY PROF. W. W. KEEN, M. D.

I. Our first case is that of a boy eleven years of age who has restricted motion in the right elbow joint. The history of the case is that four weeks ago he fell from a tree, striking on the palm of the right hand. A physician found an injury of the elbow and dressed the arm in straight splints for five days. The boy comes now with inability to flex the arm fully, and an examination shows a backward dislocation of both bones of the forearm, though the radius is not completely dislocated.

This case emphasizes two points: First, give an anesthetic in every case of elbow injury. Second, always measure the injured part and compare it with the sound side. Use instruments of precision whenever possible, as they are not liable to errors of judgment. Of course the X-rays should be used whenever this is practicable.

The boy is being anesthetized, and I shall try and reduce the dislocation, although success is rather doubtful. If this is not accomplished will operation be done at once? By no means. If this attempt fails others will be made at intervals of a few days. After three trials have been made an operation may be done, but this will depend entirely on the usefulness of the arm. The main object to be attained in these cases is to enable the patient to feed himself with the injured arm or to tie his cravat. It must be remembered that in patients at this age the condition often improves by use. One case I saw fifteen years ago was a boy of ten with the same condition as exists in this patient. Three unsuccessful efforts were made to reduce the dislocation. Operation was not done because of the usefulness of the arm at that time. But since that the range of motion has increased greatly and the man can now write perfectly well with that arm, can play golf and has a very useful arm.

A great deal of force can be used in attempting reduction in these cases if it is applied gradually and not with violence. I do not succeed in reducing the dislocation in this instance, but many adhesions have been broken up and the range of motion considerably increased. At future clinics further attempts at reduction will be made.

II. Movable Kidney.—This patient is a man of twenty-six. His history shows that he has epileptic convulsions at intervals of fifteen days to one month. One year ago he was delivered of a tapeworm twenty feet in length after having taken a meat diet for two years. Some time after this an uneasiness was felt in the right hypochondrium, and then a lump was noticed at times. This lump is smooth and movable, and at first examination I could not find it at all, but have since found it. It is too deep and solid for the gall bladder, and a temporary diagnosis of movable kidney has been made.

The patient is very nervous, as most of these cases are—nearly all approaching or reaching the condition of neurasthenia. He worries about the movable organ, and this tends to aggravate the epilepsy, hence operation is deemed advisable. Not every movable kidney should be operated upon. Many women have this condition for a time or permanently after pregnancy. Where the movability is not extreme, operation should not be done, and if the condition is discovered by the physician he should by no means let the patient know it, as this almost invariably leads to worrying or worse and a demand for operative relief.

The incision for this operation I begin at the outer border of the erector spinæ muscles, half way between the twelfth rib and the crest of the ilium, and carry it well forward. The advantage of this incision is that it can be extended to give as much room as is desired. The presence and condition of the other kidney can be ascertained. If the kidney can be sewed in place without opening the peritoneum, this will be done, otherwise it will be opened widely and exploration made.

In anchoring a floating kidney, the stitches do not hold the organ fast, but are simply to keep it in place until adhesions form. Hence great stress is not laid upon the stitching process. But I do lay great stress upon the separation of all the material from around the kidney in order to get the kidney clear and the wall clear, that the kidney may be brought directly to the wall for the adhesions to form. This separation of adhesions and clearing of the kidney is of far more importance than any question of stitches.

There is no occasion here for opening the peritoneum, so having cleaned the kidney I introduce three or four stitches of kangaroo tendon. These are passed through the capsule of the kidney and through a generous portion of the cortex as well, the anchoring being to the lumbar fascia. These cases I never drain.

There is great danger in removing a kidney when the urine shows less than two per cent, of urea. Last week, however, I removed a kidney for hydronephrosis when the urea was one and six tenths per cent. The amount of urine was large enough at the time to bring the total amount to three hundred grains daily, and as the condition of the woman was considered dangerous the operation was done.

CHARITY HOSPITAL OF LOUISIANA ALUMNI ASSOCIATION.

This Association held its sixth annual meeting in this city on April 18. There was a larger attendance than for the past two or three years, including a good country contingent.

The president, Dr. Chassaignac, was in the chair and read his address on "Medical Journalism."* The annual oration was delivered by the Rev. Dr. LaPrade, who treated of "A Prognosis from a Non-professional," referring to inordinate hurry and haste as the disease of the day; after suggesting the gravity of the prognosis if this condition were not changed, he recommended meditation and thought as the remedies. His remarks were most interesting and very well received, a vote of thanks being tendered.

The standing committees and several special committees made their reports, one of the latter urging action in recommending the election of second assistant house surgeons at the Hospital after competitive examination and that the tenure of each position on the house surgical staff be limited to four years. All reports were unanimously adopted.

The officers elected for the ensuing year were: Drs. J. D. Bloom, president; A. A. Allain, vice-president; G. K. Logan, secretary; E. Regard, treasurer; members of executive committee, E. D. Martin, H. S. Cocram, H. S. Lewis.

After adjournment a banquet was enjoyed at Antoine's Restaurant.

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* To be published next month.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE CARE OF SMALL-POX IN NEW ORLEANS.

New Orleans has just experienced an uncomfortable agitation over the care of its small-pox patients. It needed the relation of the experience of an unfortunate stranger to again call the attention of the health authorities and others to the existing conditions at the present pest house. It is universally conceded that the exposé of the conditions by the daily press has forever condemned the contract system in caring for the sick. As the *Picayune* some years ago crusaded for the better care of the lepers, then located at the pest house in New Orleans, so the *Times-Democrat* has left nothing undone in the way of ventilating the small-pox situation. Former inmates testified to the unsanitary conditions, and additionally have detailed their experiences in an institution barely supplied with ordinary domestic necessities.

The City Council deplores its inability to take active measures to remedy the evil and acknowledges the obligation in a monetary way to the incumbent contractor. So the question from the municipal standpoint remains in *statu quo*.

Some years ago the contract for the small-pox hospital was investigated by the City Council and the evils of the existing conditions were fully discussed; the contract was, however, renewed in the expectation of better service.

The contract with the present management of the pest house expires on May 11, and it is fair to assume that popular opinion, as expressed in the daily newspapers, will forbid the renewal of any arrangement of a similar sort. We are not prepared to believe that small-pox is to be a perpetuity in Louisiana or in New Orleans; for in time, if nothing else avails, the vaccination of all persons will put an end to the disease as it has in times past.

That some temporary arrangement must be made, however, is undoubted, and on this point we feel that we are justified in having an opinion.

The high percentage of mortality from small-pox in New Orleans, as evidenced by the City Board of Health in its authoritative statements (something over 32 per cent.) argues the need of provision for the treatment of such cases of small-pox as may occur in this city. Compared with other municipalities and other sections, this death rate is appallingly high. Just what may be conducive we do not know, but there seems no evident reason why New Orleans should carry the burden of such a mortality.

All governmental steps are slow in action, and no matter how urgent in demand, the procedures necessary to the expenditure of public funds are surrounded with a multitude of barriers and objections. Besides, we are forced to confess that hitherto the administration of our State institutions has been somewhat over-colored by the political equation.

That the State and the city of New Orleans owe the public both protection and care in small-pox and in other diseases, we do not question, and we moreover believe that in time the demand for such must be acknowledged and fulfilled. In the meantime, the same public owes it to itself to take some action with a view to remedying conditions which have shocked other communities in their relation, and which have been recited so as to class New Orleans methods as medieval, even if the truth may have been contorted.

Public charities have arisen because of the need of them, and the need has always awakened a responsive action among those persons of philanthropic inclinations.

Each year New Orleans expresses its charity in public entertainments, the net results from which aggregate thousands of dollars.

With the public mind as much alive as it is to-day to the small-pox situation it would be no difficult matter to raise subscriptions great enough to establish a proper institution for infectious diseases, at which not only isolation could be made complete but where, under judicious and disinterested care, the victims of disease would have the comfort and medical treatment due.

The question of the Charity Hospital and its obligation to care for the sick has been raised with regard to these particular diseases. Without any provision by the State, of course the administration of that institution can not be expected to assume any responsibility. Once, however, provision has been made and the State has relegated such diseases to their care, the responsibility will be fixed.

The character of construction of buildings for small-pox and such other contagious diseases as may need attention is a question easy of solution; for in many other cities the situation has been met and solved. In well regulated city hospitals, with the pavilion and disconnected ward systems, isolation can be made complete. Above all, we feel that the future should see adequate provision made and that in the light of recent events, that future provision should be as soon as exigential conditions demand.

FEDERAL HEALTH SUPERVISION.

The Orleans Parish Medical Society, at its meeting of April 14, passed a resolution embodying the sense of that body as urging the representatives of the State of Louisiana at the national capital to take a favorable and active position on the question of the establishment of some national health supervision. The society also passed resolutions endorsing the action of the Louisiana State Board of Health in appealing to our Representatives and Senators to press the employment of quarantine measures at all seaports on the Atlantic and Gulf coasts, with particular regard to vessels and passengers arriving from yellow fever countries. The very deduction from these two congener resolutions argues the absolute dependence of State health departments upon conditions outside of their control.

Agreement between health boards may arrange uniformity of action, but the spirit of agreement is frequently violated when the letter might obtain.

The question of national health supervision has been agitated and almost exhaustively argued pro and con, but only one conclusion has been arrived at, viz., that some such supervision is necessary.

We believe that the legislation in this direction is not far distant, and we feel, if the right kind of pressure was brought by the medical men, individually and in organized bodies, local and State, that the representatives of such men would feel disposed to act. The Southern States are particularly interested; they above all have need of protection; but we understand that of all medical men those of the South have been most idle in stimulating expressions and personal appeals to Congressmen and Senators from their sections. It is, therefore, the more commendable that our local medical organization has gone on record in the matter, and other like bodies should promptly follow suit.

The Orleans Parish Medical Society did not commit itself, nor does it commit the Louisiana delegation in Washington, to the approval of any one of the bills or amendments which are to be under consideration, the wisdom of which action is evidently more promiseful of a result than if an opinionated position had been taken. It acknowledges the need of some department or bureau of health, either independent of or subsidiary to some existing department, but it urges the need of a universal and a uniform health supervision, which State boards, no matter how well disposed, can not attain.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

Report of a Successful Case of Excision of the Cecum, with end-to-end Anastomosis.—Frederick Holme Wiggin reports in the *Journal of American Medical Association* of April 14, 1900, a successful case of excision of the cecum with end-to-end anastomosis by Maunsell's method. The case was that of a married woman fifty-four years of age. She gave a history of having had recurring attacks of appendicitis covering a period of ten years. About six weeks previously she had had a more severe attack than any previous one. Since that time she had been unable to take nourishment even in a liquid form without suffering pain in the right iliac region accompanied by severe and persistent nausea. She was emaciated, was suffering from marked mental depression, her gums and tongue were much swollen and red and there were various ecchymotic spots all over her body. Her pulse rate was 74 and her temperature 99.4 degrees. By manual examination a tumor, attached to the uterus and broad ligament and extending up to the right inguinal region was found. Incision was made over the right rectus muscle, the fibres of which were separated and the peritoneal cavity entered. The tumor involved the cecum and appendix. The adhesions being separated, the portion of intestine containing the tumor was brought outside the abdominal cavity which was shut off by gauze pads. There were no enlarged mesenteric glands, but, fearing malignant disease, the bowel was divided on either side some distance from the tumor. The mesenteric attachment was clamped off before division, after which the vessels were caught with forceps and ligated. When the tumor had been removed and the cut edges of the bowel washed with hydrogen dioxide, the cut edge of the ileum was united to that of the descending colon by means of stitches passed from within the bowel through all the coats and then through the bowel of the opposite side from without in, the knots being tied on the inside of the bowel and thus bringing together broad surfaces of peritoneum. The stitch used was the one whose utility was demonstrated by Maunsell. The slit in the colon, representing the difference in size of the two guts, was closed with Lembert's sutures. The suture material used was horse hair in a number 5 milliner's needle. The patient made a good recovery. Examination of the tumor showed no malignant elements. The chief points of interest in the case are: 1, the history of recurring attacks of appendicitis covering a long period of time, ten years; 2, the general condition of the patient, which indicated great bodily depression analogous to scurvy, due to the lack of proper nourishment, and to the retention for a long time of a large quantity of fecal matter; 3, the method of suture employed; 4, the small amount of blood lost by the patient during operation; 5, the early and constant use of saline enemas to improve the general condition of the patient; 6, the early administration of nourishment to the patient in considerable quantity; 7, the character of the tumor.

Comment.—Although the description of the method of operating is by no means clear, still since it is stated that the method employed was that demonstrated by Maunsell, and it is well known that this is the method popularized in this country by Wiggin and preferred by him, it may be taken for granted that this was the plan followed.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller,
New Orleans, La.

The Diagnosis and Management of Cystitis in Women.—The New York *Medical Journal* (April 7) contains the report of the discussion of the above named subject before the New York Obstetrical Society. Dr. Brothers referred to the symptomatology of the disease in its acute and chronic forms and emphasized the fact that, with the modern means of exact diagnosis of vesical conditions, obscure lesions were no longer a mystery. Irritable bladder is now a myth. He preferred the Nitze cystocope to Kelly's instrument, because the bladder was directly illuminated and a larger area could be seen. Furthermore, the patient's position was easier and no preliminary dilitation or anesthesia was necessary.

Inspection of the bladder was contraindicated in acute inflammations, but permissible in all other forms.

Dr. Alexander J. C. Skene found it seldom necessary to employ instrumental investigation to make a diagnosis of cystitis. The degree of cystitis could be determined by the condition of urine clearly and definitely. In some forms of ulceration, secondary pericystitis and neoplasms, the characteristic changes in the urine do not occur. In such instances the cystocope is necessary. The possibility of doing great injury to the bladder by instrumental examination during acute cystitis was dwelt upon. Such traumatism is to be feared much more than the introduction of bacteria. The necessity of catheterizing the ureters unless there was disease of the pelvis of the kidney or ureter was doubted. For topical applications the endoscope was to be preferred, but not the removal of growths.

DIAGNOSIS, PROGNOSIS AND TREATMENT OF GONORRHEA IN WOMEN.—Dr. John G. Clark contributes to the April number of the *American Journal of the Medical Sciences*, an extensive article, styled "A Critical Summary of Recent Literature on the Localization, Diagnosis, Prognosis and Treatment of Gonorrhea in Women."

He states that gonorrhea in women is much more difficult to diagnosticate than in men, chiefly because a whitish, leucorrheal discharge may be considered more or less normal in women, whereas in healthy men there is no urethral discharge. The very fact that a man has such a discharge is very strong presumptive evidence in favor of its specific origin, whereas no significance may be attached to leucorrheal discharge in women.

The certain diagnosis in women depends very largely upon the demonstration of the gonococcus in the secretions. A profuse purulent urethral discharge is quite as diagnostic as it is in men; but when it is remembered that the acute urethritis is only fleeting in character and that the disease may persist for months and years after all symptoms have subsided, it will be seen how little importance can be placed upon this sign. Its presence is of great diagnostic value, but to assume because of its absence that there is no gonorrhea would be a serious error.

In securing pus for examination the greatest precaution must be observed to avoid contamination with other organisms. For bacteriologic examination the vaginal discharge is almost valueless, because of the frequent presence of various cocci. Secretions from concealed passages are the ones to be employed. The urethra should be exposed, cleansed and the secretion removed with a platinum loop and placed on cover glass. A drop of pus may be obtained from Bartholin's duct. The cervix should always be examined, as secretions obtained directly from the cervical canal are the most reliable.

Methylen blue is the most practical and easily manipulated staining fluid. Repeated microscopic examinations are necessary. One case is mentioned where twelve negative examinations were made on successive days before the gonococcus was found.

Prognosis—Although the result of gonorrheal infection in women may be of the most serious nature, and, indeed, this is so frequently the case that one is almost inclined to say that all cases are serious, nevertheless the fact must not be lost sight of that a considerable portion of cases run a simple, mild course, and, with the exception of a more or less acute urethritis or vulvitis, no other part of the genital tract is involved.

Clark thinks the statements of Naeggerath regarding its frequency is unquestionably exaggerated. So does Bumm.

It is generally accepted that twelve per cent. of all marriages are sterile. Clark attributes eight of the twelve per cent. to gonorrhea. The localization of the infection is the deciding feature in the prognosis. It is favorable in acute gonorrhea of the cervix and urethra. If the entire genital tract is infected it is due to insufficient treatment, active exercise during menstruation, sexual excesses or the repeated infection of the wife by a chronically diseased husband.

Treatment of the wife is useless so long as the husband is infected. If the infected process gains access to the uterus and becomes chronic, the complete cure is very doubtful. According to the present status of our knowledge we can with perfect propriety try conservative methods of treatment, even in *gonorrheal pyosalpinx*, before resorting to operation.

Treatment.—Two views are held: 1st, that absolutely nothing should be done in the way of local therapeutics with a view to the self limitation of the disease; 2nd, that active germicidal remedies are indicated from the outset. The first view is upheld by no less authorities than Bumm, and by Behrens, the latter the chief examiner of prostitutes in Berlin.

They believe in absolute rest, especially during the menstrual week; that the seat of primary infection is invariably in the urethra and that the genital tract is infected by douche nozzles, examinations, etc. In rare cases injections are used. They believe in discovering the point of localization and applying topical remedies. In acute urethritis no injections should be employed; in subacute cases 1 to 1000 silver nitrate or 1 to 5 per cent. ichthyol should be injected; the fluid will not enter the bladder unless force is used.

Ichthyol is a valuable remedy. Neisser believes the silver salts superior to all other remedies. Copper, zinc and lead salts are much less employed than formerly.

In chronic urethral gonorrhea the endoscope should invariably be employed to locate the inflamed areas.

As a topical application to the vulva and vagina, a 1 to 10 per cent. solution of nitrate of silver is best.

In Bartholinitis hot applications are of service, but as a rule, complete extirpation is advisable.

If the cervix uteri only is involved, it should be thoroughly dilated, cleansed and a 1 to 5 per cent. nitrate of silver solution applied. Ichthyol (one of the best remedies) can be applied in cotton and left in situ for many hours.

If salpingitis develop, complete composure must be enjoined; cold or hot applications to the abdomen, careful regulation of the bowels and light diet. Rest is the chief point. Bumm insists upon the patient remaining two months in bed, owing to the well known tendency of the process to again become active.

After the process has invaded the tubes all forms of uterine treatment should be stopped or conducted with greatest precaution. If a pyosalpinx persists, operation must be advised.

If operation is necessary, Clark favors removing simply the tube, leaving ovaries and uterus, in contradistinction to Bumm and others, who would remove tubes, uterus and ovaries. The fact that gonorrhea is most likely to occur in young women makes one incline very strongly to the conservative line. The treatment of gonorrhea during pregnancy consists in the maintenance of absolute cleanliness, for to attempt to institute curative remedies at this time is fruitless. Vaginal irrigations should be given daily, but stopped at least a week before confinement.

Three points are developed as result of the review, viz.: Absolute rest in the acute stages of infection is one of the most important essentials; that the silver salts still maintain a very important place in treatment, and that of the new remedies ichthyol is unquestionably the most valuable.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

The Prevention and Treatment of Diarrhea in Infants.—The patients are of the age at which treatment is most difficult, and this fact renders prevention, always important, of much greater value than even the proverbial sixteen to one ratio. Still greater emphasis is to be placed upon this point because the condition is so largely a preventable one. Too much food, or that of an improper quality, will easily provoke a diarrhea. Infants fed upon cows' milk form a large proportion of the cases. Chapin finds that properly diluting the milk with decoctions of the cereals as advised by Jacobi yields the best results in his practice. He states that in general a bottle-fed baby should have less bulk of food and a higher dilution of milk in very hot weather than it has been accustomed to before. When diarrhea begins all forms of milk must be temporarily withheld. A good substitute is the white of an egg thoroughly stirred in half a glass of cold water. Ten drops of aromatic spirits of ammonia may be added to overcome the tastelessness, and it also helps check stomach irritation.

Cheseboro (*Phila. Med. Journ.*, June 17, 1899,) recommends as a working rule for the dilution of Holt's primary formula for young infants to dilute it five times for the first two weeks, four times for the next three or four weeks, etc., diluting it twice for an infant of twelve to eighteen weeks of age. Limewater should be added to overcome the acidity of the milk, and two or three grains of table salt should be added for each feeding.

Ashby finds milk-whey of great value. Prepared in the way he describes (*Edinburg Med. Journ.*), with or without the addition of three drachms of milk-sugar to the pint, it is a useful food for new born infants, or those who have chronic vomiting, or liquid, green, curdy stools.

As regards pasteurization and sterilization, the question as to which of the methods is the better is not yet settled. Individuality must be taken into account, and the preparation that gives good results in one or many cases will fail to agree with others. But all milk used during the warmer months should be either pasteurized or sterilized. There is no question as to preventing many of the cases of summer diarrhea if the proper amount of milk is given and its preparation is attended to in some of the various ways in use.

With the question of treatment comes a much more serious matter, especially in the acute cases popularly known as cholera infantum. Treatment here must be decisive and energetic. Blackader (*Progressive Med.*, Vol. 1) emphasizes the importance of giving a quick-acting purgative, castor oil, or calomel, if the stomach is irritable. The purgative is followed, if necessary, by lavage of the stomach and large intestine. Milk food should be stopped, and only sterile water or thin barley or rice water given for a few days; later small quantities of a thin broth may be alternated with the cereal food. For irrigating the colon warm, normal saline solution should be used and a pressure of only one or two feet in height maintained. The blood pressure should be raised and the pulse show more strength after the irrigation, if rightly done. Blackader advises cautiousness in the use of intestinal antiseptics, high doses causing depression. He says Continental writers strongly recommend tannigen in later stages, in four to five-grain doses four times a day. For elevated temperature, he prefers three to ten-minute tepid baths, about 95 deg. F., quickly lowered to 90 deg. or 85 deg., or still lower until temperature of the infant is distinctly influenced, great care being taken to treat depression if it should arise. Irrigation of the intestine with cool water is more powerful, but it must be used with discretion; serious depression may result if it is too cold or too long continued. The subcutaneous injection of saline solution often gives good results in cases of exhaustion, or where hydrencephoid symptoms develop.

Blech, of Chicago, is a strong advocate of eudoxin. It is non toxic.

Chapin has found the subnitrate of bismuth in large doses to be most useful, ten to twenty grain doses every two or three hours for a baby of six to twelve months. A few moderate doses of opium are most valuable when rapid peristalsis and profuse secretion persist.

Tyson recommends, after a purge, bismuth subnitrate or prepared chalk combined with a small amount of salol, adding opium to relieve pain. For the latter, mustard plasters or a spice poultice should be tried first. Astringents are seldom necessary, but compound tincture of kino is efficient. He condemns intestinal antiseptic treatment. In cholera infantum he recommends opium, preparations of silver, hydrotherapy, irrigation of the large bowel and stimulants. The 1 per cent. salt solution may be given by hypodermoclysis in cases of extreme collapse.

Osler is a warm advocate of the irrigation of both the stomach and large bowel, the former being continued until the water comes away quite clear. He says we have no reliable intestinal antiseptic, and he also believes in bismuth in large doses (two drachms a day for an infant a year old).

H. A. Hare's favorite treatment in cholera infantum (colorless stools, pasty, whitish, mousy odor), is the use of podophyllin, in one-twentieth of a grain doses for a child of six months, given in two doses, half an hour apart, in twenty drops of brandy with a little water, to be repeated every two hours until stools have a bilious color, meanwhile bodily temperature being preserved by applying to the belly a spice plaster, or by immersing the child in a hot bath for short intervals. Counter-irritation over the belly by means of a mustard or spice plaster should never be forgotten, the latter being removed as often as it cools, and kept on continuusly, if the skin will stand it. He also recommends irrigation of the bowels.—FITCH, in *Medical Times*, March, 1900.

Department of Therapeutics.

In charge of DR. J. A. STORCK, New Orleans.

INHALATION OF FORMALIN IN PHTHISIS.—The *British Medical Journal* of January 28, 1899, brought out a most interesting paper by Dr. William Murrell, dealing with the essential oils, and other volatile substances in the treatment of phthisis, in which he discards the use of essential oils, but favors the use of formaldehyde or formalin, which he subjected to severe tests for the inhibition of the bacillus tuberculosis, showing that the addition of glycerin retarded the results, which with formalin pure and simple answered all his expectations.

The cases which Dr. Murrell reports all show that with the formalin treatment without any addition, he was uniformly successful, the patient being told to inspire the substance mostly by dropping it on lint, and thus allowing it to be absorbed by inhalation.

We call to mind this contribution of Dr. Murrell, while we wish particularly to make some remarks on the paper of Dr. Lardner Green, which we find in the same journal under date of January 20, 1900.

The author fully indorses, by personal observation, the conclusions Dr. Murrell has come to, and it is satisfactory to notice that he also has applied this gas by inhalation to the full advantage of his patients. Dr. Lardner Green, however, introduces into his prescription two incompatibilities, which we consider it desirable to point out, and Dr. Murrell's data will assist or confirm, from a bacteriologic point of view, the advice not to introduce glycerin. There is, besides, an abundance of literature showing that glycerin forms with formaldehyde a chemical compound named glycerin-formol, which impairs the non-toxicity of formalin, and although this compound has been recommended for disinfecting purposes, closer study has shown that the more toxic properties of this body by no means assist antiseptic action, but rather impede it. As we said before, this has been confirmed by Dr. Murrell, and it is by no means desirable to encourage the mixing of these two bodies.

As Dr. Green has experienced, some persons are more susceptible than others to the fumes of formalin, and for this reason he recommends, where indicated, the addition of aromatic spirits of ammonia. Truly enough, this addition will effect a material reduction of the penetrating effects of formalin gas, for the very simple chemical reason that formalin gas has great affinity for ammonia, with which it readily forms a neutral compound—formamide—and, as will be understood, the binding up of formalin, thereby reducing very effectually its activity as a bactericide. The very simple logic would be, that if a patient finds the fumes of formalin irritating, that is, more so than he can conveniently bear, let him reduce the solution by a further addition of water; try half the strength, or even much less—say, one-tenth—which will still be effectual as an inhalation; but it will be found that even the sensitive patient will gradually be able to bear the greater volume of gas, similary as a visitor to the room of a patient where a free use of formalin is made will, after a very short time, fail to notice the first inconvenience of the presence of the gas.

The great advantage of formalin gas in the treatment of phthisis is shown by a great number of authors, and also that it is equal—nay, preferable—in most cases to the open-air treatment, unless the open air can be had on the top of a mountain and well removed from the contamination of a populated community. The simple reason for this is the great affinity of formalin gas for all nitrogenous and sulphur compounds, which it quickly eliminates from the air of the room occupied by the patient, and for which reason it will, under all conditions, favor the general treatment of disease and minimize its symptoms. In this respect formalin offers the inducement of further study of what can not fail to be a most gratifying subject.—*The Therapist.*

CREOSOTAL IN ACTUE PULMONARY DISEASES.—The action of creosotal in acute diseases of the lungs, such as pneumonia, bronchopneumonia, grip pneumonia, etc., Dr. F. Hoelscher says (*Tagebl. Kongr. z. Bek. d. Tuberkulose*) is even more remarkable than in chronic cases, as is shown by the researches which have just been published by Cassoute and Corgier from the hospitals of Marseilles. Pneumonia is cut short by the early administration of large doses of creosotal, and the course of the disease is noticeably shortened when the drug is administered later in the disease. The typical fall of temperature occurs in twenty-four hours after the administration of the drug. The afebrile condition is a permanent one if the exhibition of the creosotal is persisted in. The temperature rises, however, if the administration of the remedy is discontinued before the auscultory signs have completely disappeared. The sequelae that so frequently occur, and more especially tuberculosis, are completely avoided by the creosotal treatment of acute diseases of the lungs.—*Ibid.*

Miscellaneous.

INSTRUCTIONS FOR THE PREVENTION OF MALARIAL FEVER.

[Published by the Liverpool School of Tropical Diseases.*]

1. The Nature of the Disease.—Malarial fever or ague is caused by certain minute parasites which live in the corpuscles of the blood, and are called *hæmamœbidæ.*

In order to produce an attack of fever, about 250,000,000 at least of the parasites must be present in the body; while in severe cases there may be as many as a billion or more. If they are present in sufficient numbers, they can easily be found by the aid of a strong microscope in a small drop of blood drawn from the patient by pricking his skin with a needle. Sometimes, however, when the patient is not actually getting the fever, they may exist in such small numbers that they can not be readily detected in this manner.

The sudden rises of temperature which occur in this disease, and which are often accompanied by shivering (ague), are due to the parasites scattering their spores in the blood-fluid. The parasites grow up together and scatter their spores, or "eggs," simultaneously; and it is at the moment when they do so that the shivering or rise of temperature begins. The spores then occupy fresh blood corpuscles; when the fever gradually ceases and sweating comes on. After one, two, or three days, a fresh attack of fever occurs, owing to the fact that another batch of parasites, many millions in number, have reached maturity and have scattered their spores.

After a variable number of such attacks, the parasites may largely decrease in number, when the patient loses his fever for a time and feels better. At any moment, however, the number of parasites may increase again, either spontaneously or because the patient has exposed himself to the sun, or to chill, fatigue, and so on. Such relapses may occur even many years after the patient has left the malarious locality where he acquired the original infection, as, for instance, after his return from Africa to England. Between the relapses the parasites continue to live in him in comparatively small numbers; but, of course, after they have once become quite extinct, no relapse will occur unless as the result of a fresh infection.

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*For the use of residents in malarious places, but especially in East Indies.—Eds.

Besides fever, the parasites often cause other symptoms, such as enlargement of the spleen, anemia, and darkening of the skin.

Quinin kills the parasites.

2. HOW PARASITES IN GENERAL LIVE.—Men, animals, or plants in which parasites live are called their *hosts*. All parasites or their eggs pass, in some way or other, from one host to another, that is, from any infected man, animal or plant, to a healthy one. Parasites may have different and, so to speak, ingenious ways for effecting this transference. *A large number* of them employ *a second species of animal* as a go-between. Thus *tape-worms* and the worms which cause *trichinosis* live a *part* of their lives in swine as well as in men. Swine eat human offal, and men eat swine; and these parasites thus transfer themselves alternately from the one to the other. Insects are often employed in this manner. Thus dogs often have a minute worm in the blood which enters the dog's flea, and return to the same or another dog when this flea happens to be swallowed. Again, the *guinea worm* is carried by a water insect; and the worm which causes *elephantiasis* is carried by mosquitoes. We know also two important diseases of cattle, called *Tsetse fly disease* and *Texas tick fever*, which are carried, one by the Tsetse fly and the other by a cattle tick. The fact is that these suctorial insects give great facilities to parasites for passing from one host to another.

Like other parasites, the parasites which cause malarial fever must pass from one host to another, that is, must manage somehow or other to enter fresh persons to live in. Long ago it was thought likely that they too are carried by insects; and this has now been definitely proved to be the case.

3. HOW WE GET MALARIAL FEVER.—It has been stated that the malaria parasites, the *hæmamœbidæ*, are easily detected by the microscope; in fact they have a very distinctive appearance. If, now, we allow mosquitoes of the kind called *anopheles* to bite

persons infected with malaria parasites, and if we then dissect these mosquitoes, we shall easily be able to find the parasites growing also in the mosquitoes. If, on the other hand, we allow a hundred, or two hundred, or a thousand, of the same kind of mosquitoes to bite healthy persons, we shall find nothing like the parasites in them.

It is easy to watch the development of the parasites in the *anopheles* by dissecting the latter at various intervals after they have been fed. The parasites are of course sucked into the insect's stomach. From this they burrow into its body-tissues, in which they live for a week or more, and grow rapidly. On reaching maturity they produce a swarm of young, which, most remarkable to relate, enter the *poison or salivary gland* of the insect. Everyone knows the itching caused by the bite of mosquitoes. This is due to a minute drop of an irritating fluid which is injected by the insect into the wound made by its proboscis. The irritating fluid comes from the salivary gland just mentioned, and may also contain the young of the malaria parasites. Hence these young must be injected into the wound made by the mosquito's proboscis, just as a bacteriologist injects bacteria by means of a syringe into a rabbit for experiment. When so injected, the young of the malaria parasite set up infection.

That this is the case has been absolutely proved by a number of experiments made in India and Italy, and there is no doubt about it. Healthy men are attacked with malarial fever after being bitten by infected *anopheles*.

These investigations have been repeated and confirmed by many men of the highest scientific ability; and are accepted as true by the leading experts on malaria.

It has thus been proved that malarial fever, like all other parasitic diseases, is really *a catching complaint*; that is, it is communicable from the sick to the healthy by the agency of mosquitoes of the kind called *anopheles*. These mosquitoes bite a patient suffering from malarial fever, and after a week or more convey the parasites into healthy persons by their bite.

4. SOME OBSCURE POINTS EXPLAINED.—Of course it is only the *first infection* of a patient which is caused in this manner. As already mentioned, after he is once infected, he may suffer from

relapses for years—relapses which have nothing to do with mosquitoes. People who are ignorant of this often doubt the facts given above, because they find that they still get fever in places such as England, where there are no mosquitoes.

Other objectors point out that mosquitoes exist where there is no malaria. They forget that only *mosquitoes of a certain kind* carry malaria (so far as is known at present). The harmless kinds of mosquitoes may therefore abound in a place without affecting the argument. Others say that malaria exists where there are no mosquitoes. Not a single instance of this has yet been recorded after sufficient investigation. A third class of objectors say that they have become infected without being bitten by mosquitoes. But it is certain that one can be bitten without knowing it or observing any mark afterwards, especially if one is bitten during sleep, while it is easy to overlook the presence of *anopheles* altogether.

But it may now be asked: If malarial fever is only carried from man to man by mosquitoes, how comes it that the disease is connected, as we know so well it is, with stagnant water, rain fall, or disturbed soil? The answer is a very interesting one: It is because the *anopheles* do not breed in vessels of water, tubs, and so on, in which the ordinary kinds of mosquitoes breed, but as a rule only in *stagnant puddles of water on the ground*. Such puddles most commonly exist in low-lying flat localities, especially where the ground tends to be marshy, and, of course, during continuous rains. They also accumulate in places where the ground has been excavated, embanked, or trenched. Hence it is easy to see how the idea that malaria rises from marshes got about; and, of course, people formerly tried to explain the facts by the supposition that malaria is a miasm or mist which rises from damp soil. There is, however, no longer any reason at all for believing in malarial mists, and so on. The germs of malaria themselves do not rise from the soil. It is the *carriers* of the germs, the *anopheles*, that do so, or rather that rise from pools of water on the ground.

This fact also explains why draining the soil so often removes malaria, because it drains away the breeding pools of *anopheles*.

One other question requires mention. It is often thought that malarial fever may be acquired by travelers in uninhabited places. In such cases it is possible that the *anopheles* may convey the parasites from lower animals; and in fact monkeys, bats and birds are known to have parasites closely like the parasites of malaria in men, and belonging to the same zoologic family, the *hæmamœbidæ.* It is open to doubt, however, whether infection can really be acquired in uninhabited places; although, of course, relapses often occur to travelers in such places as elsewhere.

It is right to state that we can not yet say with absolute certainty that infection is produced *only* by mosquitoes, but there are numerous reasons for doubting the existence of any other route for infection; while, at all events, the mosquito theory will help us to prevent a great deal of fever.

5. FACTS ABOUT MOSQUITOES.—Mosquitoes are zoologically the same as gnats.

They do not originate from grass and trees, as some people think; but from those little wriggling brown creatures, called wrigglers, which are found so commonly in tubs of water, and wriggle to the bottom on being disturbed. These creatures are the *larvae* from which mosquitoes develop, just as butterflies develop from caterpillars.

The larvae *must* live in water. They take about a week to grow from the egg to the chrysalis stage, called the *pupa.* The pupa lives for one or two days, also in water; and then the adult winged insect rises from it and flies away.

The adult mosquitoes do not live only for one day, as people think. They may live for *months*, and have been kept alive in glass tubes for ten weeks. In Italy they can hibernate all through the winter. They feed on fruit, birds, animals, as well as on man; but only the females suck blood, the males living on fruit, and possibly leaves. After feeding on a man or animal, the female generally sleeps gorged all day on the wall of a room or other place. Every few days she has to fly back to the water where she lived as a larvae, or to some other suitable spot, to lay her eggs; and return afterwards, probably to the place where she first obtained food. Hence, mosquitoes which feed on human beings generally breed in water, *close to houses.*

Gnats and mosquitoes are scientifically known as *culicidæ.* We already know some 200 species. These are divided into several groups called genera. The commonest genera are called *culex* and *anopheles*, and it is important to know how to distinguish between them, because *anopheles* carry malaria, while the *culex* appears to be harmless. This can be done by any one at a glance.

Anopheles have a slim, elegant body, shaped like that of a humming bird moth; a small head and a long, thick proboscis. When seated on a wall the axis of the *body is almost* at right angles to the wall, and they generally have spotted wings. The *culex* have a coarser body, with a thick *thorax* or chest and a thin proboscis. When seated on a wall the tail hangs downward, or even points a little toward the wall, and the wings are generally quite plain. Observe also that the wings of the *anopheles* are spotted along the front edge.

The larvæ of the two kinds are equally different from each other. Those of the *culex* float when at rest on the surface of the water, suspended by their tails and their heads hanging downward, and when disturbed they *wriggle at once* to the bottom. But those of *anopheles* float flat on the surface of the water like sticks, and when disturbed wriggle *on the surface* with a backwark *skating* movement. Then the *larvæ* of the *culex* are found almost entirely in *artificial* collections of water, such as tubs, pots, broken bottles, cisterns and drains; while those of *anopheles* prefer *natural* collections of water, chiefly rainwater puddles which do not dry up too quickly, which do not contain small fish, and which are not liable to be scoured out by heavy rains; and may also be found sometimes in small ponds and submerged rice fields.

With a little practice any one can learn to distinguish between these kinds of mosquitoes at sight. It is interesting to keep the larvae in bottles half full of water; they soon hatch into adults. The adult winged insect can easily be caught alive when seated asleep on a wall, by placing the mouth of a bottle *slowly* over them; and if a little water be put in the bottle they will soon lay their eggs in it.

Males can be distinguished from females by their possessing feathery *antennae* on their heads. It should be added that *anopheles* larvæ are very fond of puddles containing green water weed; and when in captivity require to be fed on this green water weed. (See also paragraph 8.)

6. Modes of Prevention.—We must—

(1) Avoid being bitten by mosquitoes as much as possible.

(2) Kill mosquitoes or their larvae, especially *anopheles*, or prevent them breeding around our houses.

No mode of preventive inoculation against malaria is yet known.

7. How to Avoid Being Bitten.—Unfortunately this is not always possible, but a careful person can certainly avoid being bitten to a very large extent; and the less one is bitten the smaller are the chances of infection.

Mosquito nets on the bed should invariably be used in all malarious countries, even when night punkahs are available, and during the hottest weather. They are often employed in a very unintelligent manner. French nets and nets hung from rings should be avoided, because they fall round the bed in heavy folds, which are hot and close. The nets should be square, should be hung inside a frame work, tucked carefully under the mattress all round, and stretched tight so as to allow air to pass through easily. The roof should be made of netting like the rest of the net, and not of long cloth. No rents, holes, or apertures should be allowed, and the net should never hang loosely round the bed down to the floor; because mosquitoes can find their way through the smallest opening. The mesh may be large, except when sand-flies are present, because mosquitoes can not get through ordinary meshes. The hands and feet are often bitten by being thrust against the net during sleep; this can be prevented by having a loose frill or valance sewn on the net a foot above the mattress and also tucked under it. Where punkahs are available they should swing above the mosquito net. Nets should be generally used for afternoon sleep as well as at night. On getting into bed, one should slip inside the net as carefully as possible, in order to avoid giving ingress to mosquitoes as well. If mosquitoes are found inside the next morning, it is due only to carelessness. Servants should be instructed to let down the nets before dark, and to tuck them carefully under the mattress. Close attention to these details will save much sickness.*

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* This is already well understood in Louisiana.—Eds.

Punkahs should be employed as much as possible, as they are in India. *Anopheles* often bite in the daytime, but are kept off by the use of punkahs. Flannel socks, in preference to cotton ones, preserve the ankles. Oil of lavender and some patent medicines are often recommended for keeping off the insects; but are not to be implicitly trusted.

Numbers of people fancy that mosquitoes will not bite them. The truth generally is that they do not feel the bites, to which some individuals are very callous. Such fancies seldom stand the test of experiment, and persons who entertain them are often the victims of chronic malaria.

Care in the exercise of these precautions should be redoubled in houses where *anopheles* are present; and also by travelers, when they are obliged to sleep in hotels, rest-houses, or the houses of natives, where old infected mosquitoes may often abound.

Patients suffering from fever, or who have lately suffered from fever, should always remember that they are capable of spreading the disease to others through the agency of mosquitoes, and are even capable of *reinfecting themselves* through the same agency. They can not, therefore, be too careful to avoid being bitten. This fact should also be remembered by those who live in the same house with patients, and are therefore especially liable to catch the disease from them.

8. HOW TO DESTROY MOSQUITOES.—These precautions against being bitten should always be taken in malarious places; but at the same time people should try to rid their houses of mosquitoes as much as possible; and experience shows that this can generally be done to a very large extent in most places by the exercise of a little care and common sense. The fact is that the presence of many mosquitoes in a house is generally a sign of slovenly house-keeping, just as the presence of other vermin is, and is almost always due to the stupidity or laziness of the inmates.

It has been mentioned (paragraph 5) that, as a rule, man-eating mosquitoes like to breed close to houses, and that the *culex* larvae live in *vessels* of water, and *anopheles* larvæ in *pools*. The first thing to do is to search carefully in and around the house for vessels and pools of water; and if there are many mosquitoes in the house, we may be almost sure that we shall presently find their larvæ somewhere close by. Thus *culex* larvae swarm in any old tub or pot of water; in broken bottles, old gourds, flower-pots, cisterns, garden fountains, and even in buckets of water kept for cooling soda water or washing plates; or in those small tins of water placed beneath the feet of tables and meat-safes to keep ants away. They may also swarm in drains and small ditches. To find the larvæ, all that a person has to do is to go and look for them in places like these; he is sure to come across them almost immediately, and will recognize them at once from the descriptions in paragraph 5. We often find little red, wormlike creatures mixed with the mosquito larvae; these are not mosquito larvæ, but the larvae of midges.

To find *anopheles* larvæ we must generally go further afield. Small pools on the ground containing green water weed, especially rain water puddles by the side of roads and paths, are their favorite haunts; but they may also be found in puddles on the surface of roads, or in hollows in rocks, in old wells, in drains, in small pools and rice fields, or even in "sloppy" ground amongst grass, or around stables or cattle byres. To find them we must simply go and look for them; and this should always be done if adult *anopheles* are seen in the house, or even if they are not actually seen, but if fresh cases of malaria are occurring close by. Stables and servants' go-downs are very favorite haunts for adult *anopheles*.

Now, in order to kill mosquitoes wholesale, it is necessary only to destroy their larvæ. This is generally a very easy matter, especially in regard to the *culex*. We have only to go around the premises at least once a week and to *empty out all pots and vessels containing stagnant water, and also to brush out with a broom all puddles containing larvæ.* As the larvæ take about a week to mature, this procedure will generally be enough to keep the insects away, but, at the same time, it is necessary to *prevent water collecting anywhere near the house.* These duties should be attended to by reliable persons, and *should not be left to native servants.*

If mosquitoes are numerous in a house, they will generally be found to be *breeding just outside the windows.* Hence people can generally keep their houses comparatively free of these pests simply by *attending to their own premises.* It often happens in towns, however, where houses are crowded together, that a neighbor is so obliging as to breed thousands of mosquitoes daily for the supply of the adjacent dwellings. In such cases a copy of this pamphlet may be sent him, with any remarks which may be considered suitable; and if he does not attend to these, the local municipality may be referred to.

Generally speaking, great stupidity is shown in towns in warm countries with regard to the absence of all check to the breeding of mosquitoes. Prominent citizens should lay the matter strongly before municipalities; and all municipalities should employ at least one special agent for the destruction and prevention of mosquitoes.

But while small collections of water can easily be emptied out or brushed away, it is often more difficult, perhaps sometimes impossible, to deal with the larger collections of water in which mosquitoes, especially the dangerous ones, breed. In such cases the following measures are to be used:

(1) All useless collections of water in which mosquitoes breed should be filled up or drained away, if this can be done at a reasonable cost.

(2) If this can not be done, recourse must be had to the *habitual* use of *culicicides.*

It is unnecessary to discuss methods of draining or filling up stagnant pools; but the subject of culicicides requires close attention. The simplest culicicide is oil, especially kerosene oil (paraffin). This, if sprinkled on the surface of water, produces a fine film, which destroys the larvæ by choking their air-tubes, or perhaps by annulling the surface-tension of the water. But the film must spread all over the surface of the water, and must last for at least half an hour. The oil can be best applied by "painting" the pool with a rag fixed on a stick, and first dipped in a pot of oil; in this manner numbers of pools can be dealt with in five minutes at the expense of very little oil.

Perhaps more permanent oil than kerosene would be more permanently effective. Fresh tar dropped in a puddle makes a film like that of oil, and has been favorably reported on. Quicklime has been suggested; and all these should certainly be tried. But the ideal culicicide still remains to be discovered. It should be some cheap solid substance or powder, which, even when in very small quantity, kills larvæ without injuring higher animals, and which dissolves so slowly in water that it will render a pool uninhabitable for larvæ for a long time.

Whatever fugitive culicicide is used, it must be used at least once a week. Cisterns and wells of drinking water should be kept covered in as much as possible.

It is sometimes impossible to find the breeding pools of *anopheles*, even where the adults are numerous in a house. This is especially the case when there is much rank vegetation round the house. Here much good can be done by simply killing the adult insects as they sleep on the walls during the day-time. Fly-flappers should be used; it is dangerous to kill mosquitoes with the hands, because the insects sometimes contain parasites which cause elephantiasis. [*Barbadoes-leg*, almost unknown in the United States.—EDS.].

9. HOUSES FOR EUROPEANS IN THE TROPICS.—These should, if possible, be built on high or sloping ground, and far from *anopheles* pools. They should not be crowded together. They should be distant from native quarters. Each should be surrounded by a large, open compound, from which all rank vegetation should be cleared away. In damp, malarious places they should be built of two stories. Trees should not be allowed very near the house. The premises should be kept entirely free of stagnant surface-water. Wells should be kept covered. Flowers should not be placed in pots on the verandah.

10. MALARIA ON SHIPS.—*Anopheles* often come on board ships from the shore in large numbers, and may then live on board for two weeks. They may bring the infection with them when they arrive; but it is more probable that they spread the infection from sick men or coolies already on board the ship. The following measures should be adopted:

(1) Sick coolies should be banished.

(2) Sick men should sleep in mosquito-nets, even for weeks after they have recovered from the actual fever.

(3) Every day men should be sent round the ship, especially into the sleeping cabins and crew's quarters, to kill all the mosquitoes they can find.

Medical News Items.

THE LOUISIANA STATE MEDICAL SOCIETY held its twenty-first annual meeting in New Orleans on April 19, 20 and 21. The attendance was good throughout and the programme was interesting and well fulfilled. The sessions were held at the Medical Department of Tulane University, through the courtesy of the faculty of that institution. The plan of general discussions under each section proved a success, and the fact that these had been announced some time in advance added materially in making the discussion general. Each day was full of business and medical interest, and there was a noticeable harmony throughout which is promiseful of larger and more interesting meetings hereafter. The Citizens' Protective Association of New Orleans aided materially in the entertainment of the physicians from the country parishes and were awarded the deserved thanks of the society. Altogether more professional spirit was shown at this meeting than at any in the past, and it was generally conceded to be one of the best meetings the society has yet had. The sessions and the detail of business accomplished follow:

FIRST DAY.—*Morning Session.* The President, Dr. W. G. Owen, of White Castle, called the meeting to order promptly at 10 o'clock, with a good quorum present. The minutes of last year's meeting were dispensed with, as they had been already published and distributed to each member.

DR. ISADORE DYER, chairman of the arrangements committee, speaking for the other members, Drs. Dupaquier and Oechsner, reported that a little different procedure had been adopted this year from those of previous years in order to stimulate a larger meeting and a more interesting program. Two successive preliminary circulars and programs were issued—the first asking for papers, and the second announcing the subjects for general discussion in each section. Heretofore no knowledge of the matters of debate was had until the meeting was called. This year, by announcing a series of subjects in each branch, all members were advised some time ahead of the proposed questions to be brought up. The success of this scheme is evidenced by the completed program submitted.

The committee announced that, in addition to the regular medical program, it has secured the offices of Judge W. W. Howe, of New Orleans, to deliver an address on "Expert Testimony" on the evening of the second day of the meeting.

The committee issued an invitation to the country members to participate in the banquet to be given Saturday night at West End. The committee urged the country members to remain over Sunday, as the social features of the meeting tend to promote a better spirit in the society.

Dr. Dyer further announced that the Citizens' Protective Association had invited the society to a buffet lunch in the banquet room of the St. Charles Hotel at 1 o'clock on Saturday. At 4 o'clock this same body will have in waiting special cars for a trolley excursion around the city. This ride is to conclude at West End in time for the banquet.

Dr. H. B. Gessner, secretary, reported that the transactions for 1898 and 1899 have been published and distributed. He asked to be informed whether he should continue to carry on the rolls members who are, and evidently have been for some time, out of touch with the society.

Dr. A. G. Friedrrichs, corresponding secretary, reported that in the early part of June, last year, he sent to each vice president, excepting the vice presidents of the First and Second districts, a list of names of the practitioners in the district for which they were elected, and with the list was included a registry blank with the request that they make corrections of the lists and forward them to the president. There are eleven local societies in the State, and the registered practitioners in this State number as follows:

Orleans Parish, 153; Plaquemines, 6; Attakapas, 75; Avoyelles, 15; Ouachita, 18; Shreveport Medical, 21; North Louisiana Medical, 36; Baton Rouge, 13; Warren Stone Society, 10; Tensas Medical, 11; Morehouse Medical, 17.

Dr. H. S. Cocram, treasurer, reported that during the current year the expenses of the society were unusually heavy. From May 16, 1899, to April 19, 1900, $1271.25 has been paid out. On May 27, 1999, $613.07 was paid for the transactions of the meeting in 1898. On March 15, 1900, $343 was paid for the transactions of 1900. Dues from May 1, 1899, to April, 1900, amounted to $1396.25. Every bill paid; there is a balance in bank of $800. Many members are still in arrears from one to five years.

A large number of applications for membership were received and referred to the membership committee.

Reports of several committees were read, on Necrology, etc.

THE STATE BOARD OF MEDICAL EXAMINERS reported that during the past year ninety-seven candidates were examined for license to practice medicine and surgery in this State. Twenty of them failed. The board presented several points relating to the workings of the present medical law. The curriculum of study has been advanced in the leading medical colleges throughout the country, and at the last meeting of the board a resolution was passed that all applicants for examination should not only possess a diploma from a reputable medical college, but shall have attended four courses of lectures in different years in legally incorporated medical colleges prior to the granting of a degree. This rule applies only to those who matriculated after January 1, 1900. All applicants from foreign countries must present evidence that they possess the full right to practice medicine in all its branches in their respective countries, and present a diploma from a college whose standard of medical education is equal to that of the leading colleges of this country requiring four courses of lectures. It would be a step in the right direction, and would materially advance the interest of the entire medical profession and completely crush out of existence inferior colleges, simply organized for financial gain, if the boards of the different States would reach an agreement looking to the recognition of certification issued by the medical examining boards when their standards of requirements are made practically the same. It is rather hard when an applicant has successfully fulfilled the requirements of a licensing board, whose standard has been proven to be among the best, to be forced to have the annoyance and expense of appearing for another examination simply because he moves his home to another State. At the present time this board does not accept any certificate; but in the near future there should be a general reciprocity of medical license in the different States, when there will be adopted a uniform minimum standard of requirements both academical and medical among the several State boards. The present medical law has been in existence six years (since August, 1894), and it has steadily grown in favor with the profession of this State.

The law is based upon the broad principles of the protection of the people, and the general elevation of the medical education. This conclusion is founded not only upon the workings of the board for the past six years, but from a knowledge of laws governing other boards in different States, where the percentage required to successfully pass the examination has been raised from year to year. The standard demanded of applicants for certificates to practice has elevated the profession upon a higher plane that it has heretofore occupied, and has assisted in driving from the State medical impostors and quacks. The charlatan and the irregular, however, are not the only infractors of the medical law, and there are a number of graduates from reputable colleges who have located in sparsely settled communities of this State, and who refused to appear before the board. The law makes it mandatory upon district attorneys to prosecute such cases when duly brought to their attention, but they refuse or delay to institute legal proceedings against such violators, through fear of loss of votes or political standing.

This board requires that applicants for admission to the examination in midwifery must have studied obstetrics at least eight months under the guidance of a reputable physician. Yet, with all the safeguards and requirements that can be enforced, a rather illiterate class of women applies for license, and over 70 per cent. of the applicants are rejected.

The board regrets that the term of Dr. T. G. Ford. of Shreveport, expires in August. Dr. Ford was appointed to fill the unexpired term of Dr. Egan. In leaving, he will take with him the sincere appreciation of the board for the good work and wise counsel he has at all times given.

THE JUDICIARY COMMITTEE—Through Dr. P. E. Archinard, Acting Chairman, reported favorably upon the following applicants, who were then duly elected:

S. L. Allen, Pine Grove; S. A. Ayo, Thibodaux; S. H. Backus, E. A. Blount, L. L. Cazenavette, C. N. Chavigny, T. S. Dabney, Edmund Moss, M. H. Maguire, H. Oechsner, W M Perkins, E. B. Preis, R. W. Salter, New Orleans; P. J. Dansereau, Labadieville; R. L. Luckett, Alexandria; E. O. Powers, Grangeville; G. Richard, Leonville; R. O. Simmons, Alexandria; M. L. Hoffpauer, Crowley; S. D. Porter, Moreauville.

Dr. VICTOR LEHMANN—Of Hahnville, read a paper on "Improved Method of Vaccination," after which the morning session was adjourned.

Afternoon Session.—The meeting was called to order at 2:30 P. M., and the program was taken up with the general discussions. The chairman of the Section on General Medicine, DR. J. A. STORCK, read an elaborate paper on several phases of the question of "Tuberculosis", which was supplemented by a paper referring to the bacteriology and pathology of the disease, by DR. O. L. POTHIER, of New Orleans.

The rest of the session was occupied by the Section on Surgery; DR. R. MATAS, of New Orleans, the chairman, read an elaborate paper of nearly an hour's length, on "Local and Regional Anesthesia, in its application to Minor and Major Surgery," the discussion being continued by Dr. F. W. Parham and Dr. Geo. W. Lewis, of New Orleans.

Night Session.—After the president had called the meeting to order, DR. HENRY DICKSON BRUNS, of New Orleans, chairman of the Section on Ophthalmology, thoroughly discussed the subject of "The Prevention of Blindness," presenting a valuable and interesting review of the several contributory causes to this condition.

DR. E. M. DUPAQUIER followed with a timely and exhaustive paper on "Measles and Small-pox in Children." The difficulties in diagnosis and treatment, the modern view on each, the indications and contraindications for treating and medication were all brought out. The paper was discussed at length by DR. JNO. F. OECHSNER, of New Orleans, and after various points were brought out by Dr. T. J. Woolf, of New Iberia; Drs. Isadore Dyer, A. W. De Roaldes, Gordon King, Erasmus Fenner, J. D. Bloom and Wm. Scheppegrell, of New Orleans.

DR. A. W. DE ROALDES, of New Orleans, as chairman of the Section on Otology, Laryngolgy and Rhinology, presented a paper "On the Management of Foreign Bodies in the Air Passage." Dr. De Roaldes, after citing several instances of pins, buttons, seeds, peanuts, grains of corn, and of coins, etc., which had lodged in the air passages, advocated recourse to a surgical operation. Dr. De Roaldes cited a remarkable feat in surgery which was very recently performed by Dr. H. Von Schwetter in the clinical department of the University of Vienna. A boy 12 years of age had swallowed a piece of lead as large as a half sovereign which passing through the trachea, descended into a bronchus of the second order. Dr. Schwetter extracted it without tracheotomy and even without anesthetics. The operation was, nevertheless, painless. This, it appears, is the first time that a bronchus of the second order has been penetrated and a foreign body extracted without a surgical operation. The operation was effected under the guidance of Dr. Schwetter's eyes. First by means of the X ray it had been located at the level of the fourth rib; then Killian's bronchoscope was introduced into the trachea and electrically lighted up. The lead was extracted by forceps constructed for the purpose. Killian has succeeded only once in introducing the bronchoscope into the tube of the first order without tracheotomy.

The discussion was opened by Dr. C. J. Landfried, and followed by Drs. Gordon King and W. Scheppegrell.

At midnight the meeting adjourned.

SECOND DAY—*Morning Session.*—The President, Dr. W. G. Owen, called the meeting to order at 10 o'clock.

The minutes of the preceding day were read and approved.

Upon the recommendation of the secretary all the accumulated medical volumes and reports of the State Medical Society were voted as a donation to the Orleans Parish Medical Society, to be preserved in their library.

After some discussion it was voted to drop all members of the society in arrears for two or more years.

It was also voted that the secretary have 1000 copies of the constitution and by-laws printed, together with a revised list of the members of the society, and the secretary was instructed to distribute these to the members.

The Judiciary Committee reported favorably upon the following applicants, who were duly elected:

Drs. S. D. Bevill, Alexandria; H. L. Ducroq, Lafourche Crossing; Dixie Foster, Franklin; P. F. Frère, Glencoe; C. H. Gardner, Bristol; W. H. Graham, Lake End; C. J. Grémillion, Alexandria; R. S. Hawkins, Palmetto; R. P. Jones, Clinton; John L. Wilson, Alexandria; G. L. Monin, Mansura; R. L. Gullidge, Rush Point; N. C. Stevens, Anna; J. V. Bugnoi, Pointe-à-la-Hache; E. A. Robin, Philip Asher, L. Périlliat, S. E. Hale, Paul Gelpi, New Orleans; R. F. Harrell, S. L. White, Lincoln; R. H. Aldrich, East Baton Rouge; S. P. Herring, Tensas; N. A. Lancaster, Newellton; W. R. Purnell, Ashwood; E. T. Vennell, St. Joseph.

Dr. J. A. Storck proposed the following resolution which was duly carried:

"Resolved, That the Louisiana State Medical Society memorialize the Board of Health and the School Board, pointing out the danger of infection from tuberculosis, and suggest to them that a circular be issued on the prophylaxis of tuberculosis: and that a copy of this circular be placed in the hands of every school teacher in the State, private and public; also, that a copy of the said circular be posted in a conspicuous place in every factory, store, street car and workshop; and, further, that the daily press be asked to lend their powerful influence to help educate the people on this most important matter."

Afternoon Session.—The president in the chair. Meeting called at 2:30 P. M.

Dr. A. R. Robertson, of Pass Christian, Miss., reported a case of "Recurrent Exfoliative Dematitis," and exhibited specimens of the shedding skin.

Under the Section on Anatomy and Physiology, Dr. S. P. Delaup read a timely and able paper on "Vivisection Considered as a Necessity for Medical Progress."

Dr. Delaup said that in view of the fact that Congress is about to act on the anti-vivisection bill, it is timely and proper to offer for discussion this most important question. The medical profession is practically unanimous in its opinion of the harmfulness of the measure, which formerly was: "A bill for the further prevention of cruelty to animals in the District of Columbia," and is now pending under a new title, "A bill for the regulation of scientific experiments in the District of Columbia." It is in this harmless guise that the Humane Society of Washington is endeavoring to usurp to itself the power of controlling all animal experimentation, not only in the government laboratories, but also in those of the medical schools and of private individuals. The advocates of the bill are in favor of abolishing imaginary cruelities by means of carefully-issued licenses and a system of regular and irregular inspections.

The crusade of the anti-vivisectionists has been a series of equivocations, misrepresentations and half truths. Scientific experimenters of the world are directly charged with brutal, inhuman and cruel conduct towards animals in carrying out their experiments and investigations. Physicians are charged with being participators or accomplices in those so-called atrocities, and it is charged also that no real advance in medical knowledge, which could not have been made without it, has followed as a result of vivisection. The charge directed against physicians is a gratuitous insult to a profession animated by the most self-sacrificing and humane instincts. This fact being appreciated, the people will concede that the medical profession, animated by noble and disinterested motives, makes vivisections and all other experiments and investigations in the interest of science, truth and humanity, and not for the mere sake of performing experiments.

The progress of medicine, from the time of the discovery of the circulation of the blood to the present time, has rested, in a very large measure, upon discoveries by experiments upon animals. By such vivisection we learned how blood nourished the tissues; how chyle is carried into the blood; how the process of intestinal digestion is carried on; the difference between the motor and sensory functions of the spinal nerves; the physiology of the brain and its functions.

The establishment of the germ theory of disease; the prevention of child-bed fever; the anti-toxin treatment of diseases other than diphtheria; the prevention of rabies by Pasteur's method of inoculation, etc., are some of the few among hundreds of valuable discoveries due to experiments upon animals. Countless thousands of human lives have been saved and will be saved by experiments of that character.

Nearly all of our knowledge of physiology, much of that of chemistry, and many of the greatest advances in curing or stamping out disease have resulted directly from vivisection.

Dr. Chassaignac presented his report as Chairman of Section on Genito-Urinary Surgery, saying in part: "In order to introduce the discussion on the subject, I would briefly mention what I would consider perhaps the most prominent indications in the selection of the method of treatment for stricture of urethra, laying stress particularly on one method, which is the newest, the least understood, one which a great many, apparently, have discussed without having the necessary data at hand.

There are four methods to select from. First, that called by dilatation, a term which I do not like, claiming that the benefit produced is by pressure. Second, the method by linear electrolysis. Third, internal urethrotomy. Fourth, external urethrotomy.

I put them in that order advisedly, believing that the cases which can be treated successfully by pressure are the most numerous. Also, when a case can not be properly treated by this method, the next best thing to do is to dispose of it by linear electrolysis. When either of these two methods will not do, we must next consider internal urethrotomy. I reserve for external urethrotomy the cases which can not be disposed of by any of the other three methods.

Of course there are exceptions to all rules, and it is impossible to lay down invariable lines to follow, but I think that we have general principles to observe in the vast majority of instances.

The method by pressure is the best whenever it can be used, if there is no special reason to do otherwise. If the case is a recent one, in which you can pass an instrument and thereby start absorption by pressure, and having this go on rapidly, we can not do any better than resort to the use of sounds.

If the case has gone beyond that, if it has become so marked that you can not pass an instrument of respectable size, or, even if you can do that, but you find that absorption is not going on satisfactorily, or, even if you believe pressure would be sufficient, yet the patient is anxious to have his canal re-established rapidly, then linear electrolysis is advisable.

If, on the other hand, the patient is badly strictured, and especially from a firm, long organized constriction—tough, then you can not depend on linear electrolysis, especially if it extends a good deal longitudinally, then it would be wise not to depend on linear electrolysis, and the method would be by internal urethrotomy, reserving for external urethrotomy the cases that are impassable, or in which a large amount of cicatricial tissue requires dissection.

There are exceptions to these rules. We have to use our judgment, finally, in the consideration of the individual cases.

I wish to start discussion, and call attention particularly to the method of treatment by linear electrolysis.

I have been using this method for about five years. It was devised by Dr. Fort, who had been using it for a number of years. I saw his results myself in Paris, and convinced that the operation had its advantages, in properly selected cases, I used it when I got back home. Four years ago I read a paper at the meeting of this society reciting the advantages of the operation, and reported some cases. I will not go over the ground that was covered then, but I will simply read, with your permission, a few advantages which I considered at the time as being in favor of the operation. (See Transactions of 1896.)

At the time, there were reasons for advocating the operation in the properly selected cases, but I could say little about the permanency of results, because I had been operating in that manner for about a year. The time was too short, not only on account of the number of cases, but also on account of time having elapsed since the operations. Four years after, I am prepared to say that the permanency of the results is perhaps superior to that obtained from internal urethrotomy.

I will mention only two cases, because they are striking, coming under my observation within the last three weeks, and have decided me to lay stress on this operation.

A physician was operated on four years ago by electrolysis, and a tight stricture opened by means of the electrolyser at one sitting. A few days after, I passed a large bougie without any difficulty. I passed a bougie only another time previous to his departure. I heard from him once or twice afterward, reporting that he was doing very well. He came to my office just about three weeks ago, not having been to the city since. I was surprised to learn that notwithstanding my instructions, and what he knew ought to have been done, he had not put anything in his urethra from the time he left. He remembered the size of the bougie I had used. I took the identical size and passed it through the urethra without any difficulty. That is a striking illustration. I doubt whether you can expect that after a cutting operation.

The other case was that of a layman who lives in Yazoo City, Mississippi. He was operated on about the same time as the other. He came to see me two years after the operation, not having seen any one in the meantime. I passed a bougie of the same size as the first one. He came to my office two weeks ago, again not having had anything passed through his urethra, after an interval of two years, and I passed a larger bougie than the previous.

It is now five years since I have resorted to this treatment, both at the hospital and in private practice; and my experience now is that the results are very satisfactory.

The discussion was participated in by Drs. T. E. Schumpert, of Shreveport; W. K. Otis, of New York, and Paul Gelpi, of New Orleans.

The following papers were then read in the order named: "Complete Transposition of the Viscera, Repalofa Case," by DR. DELAUP; on "Suprapubic Cystotomy and Retrograde Catheterization in Complete Laceration of Urethra," by Dr. C. J. DUCOTE, of Cottonport.

DR. G. A. B. HAYS, chairman of the Section on Mental Diseases, read a paper on the "Care and Treatment of the Insane," referring especially to the Jackson (La.) Insane Asylum, of which the doctor is in charge. Dr. Hays told how the inmates of the State Insane Asylum take delight in cultivating the garden, in fishing and in attending the weekly ball. They are constant readers of newspapers and periodicals, and they show interest in war news, in politics and in all questions of the day. They make frequent excursions out in the country among the hills and in the woods. The women return with great masses of wild flowers, with which they decorate the halls and rooms. The attending physician should try to win the confidence of the patient and to bring back his mind into normal channels. He who succeeds in reclaiming one of those unfortunate beings has rendered an inestimable service to humanity, for death is preferable to hopeless insanity.

DR. A. L. METZ, of New Orleans, read a paper on the "Pullen Case," from a Toxicological standpoint. This was the celebrated poisoning case which occurred in this city in August, 1899. Dr. Metz did not go into any discussion as to motive or intent, but spoke of the case from a purely scientific standpoint, especially laying stress on the character of the arsenic found in the stomach contents in determining whether it had been ingested *ante-mortem* or was from the embalming fluid.

Dr. V. Lehmann, of Hahnville, St. Charles parish, read a paper on "The Successful Treatment of Variola."

At the opening of the session Dr. T. L. Dabney, of New Orleans read an interesting paper on "The Physiological Treatment of Typhoid Fever."

Night Session.—Dr. W. G. Owen, president, read his annual report. Dr. Owen said it gave him great pleasure to meet the members, and in the name of the society returned thanks to the able committee on arrangements, not only for the literary feast they provided for their entertainment, but also for the hospitalities of this great city, which they had so freely extended. After reviewing the work of the past year, Dr. Owen said that the creation of Boards of State Medical Examiners has exercised a most invigorating influence upon the medical colleges throughout the country. All of them had lengthened their periods of instruction, besides introducing numerous other qualifications before conferring the doctorate upon the aspirant.

Dr. Owen made three recommendations. He suggested that a special section on sanitary science be created; and that the health officer of each parish and municipality in the State be ex-officio a member thereof. The local Boards of Health will undoubtedly insist upon the attendance of their health officer at the conventions of the society. This will not only have the tendency of making the society more truly representative by having one or more physicians present from every parish in Louisiana, but it will also enable it to participate in shaping the policy of the public health.

On the other hand, this will be an invaluable source of instruction to the health officers themselves, as a result of the attention required by the interchange of ideas, etc. The president also recommended that the certificate of membership be issued at cost price to each member who may desire it; that The New Orleans Medical and Surgical Journal be made the official organ of this society. In conclusion, Dr. Owen thanked the fellow officers and members for their uniform kindness and courtesy, and said it was pleasing for him to preside over such an intelligent body of professional men.

Dr. Dyer, as chairman of the Committee of Arrangements, introduced Judge W. W. Howe, of New Orleans, who delivered, by special invitation, an address on "Expert Testimony." The judge said that there were many bonds of sympathy between the medical and the legal professions, both being learned professions, and their prominent members claim to have something in view beyond the mere acquisition of money. From one point of view the practice of either profession is an art, but from another point of view it is the study and application of great principles of science. They have another thing in common—they are often called to assist the poor and friendless or to do some work on behalf of the public in a spirit of charity, benevolence or patriotism.

The use of experts in various kinds of legal proceedings is as old as civilization itself. After citing a number of mistakes that resulted from the acceptance of expert evidence in criminal cases, Judge Howe said that notwithstanding those mistakes there must be expert evidence. Physicians and surgeons will probably for all time be called to testify in matters that pertain to their art or science. When a physician testifies as an expert his function is quasi-judicial. They have no more right to swerve from the line of impartiality than has the judge. They may be full of good intentions, and may be good, sincere men, but they can be causes of much mischief in cases involving the property, the life or the liberty of others.

The first essential quality of the medical witness should be that impartial spirit which will enable him to occupy and preserve a judicial attitude towards the parties and the cause. And the second essential quality is that wide and deep knowledge of the subject concerned, without which he should never consent to go upon the stand. "No one," said Jowett, "is infallible—even the youngest of us." The best expert may err. But the probability of error will be largely reduced if the witness be, in the first place, candid and impartial, and, in the second place, if he have that profound knowledge of the question in hand, without which he ought never to venture an opinion. These considerations ought to have an important place in the domain of medical ethics.

Judge Howe received applause and a unanimous vote of thanks for his appreciated discourse.

Papers were read and discussed in the following order: "Some Suggestions in Bone Suturing," by Dr. E. Denègre Martin, New Orleans; "Report of a Case of Chronic Empyemia of the Antrum of Highmore, Radically Cure by the Caldwell-Luc Operation," by Dr. L. de Poorter, New Orleans; "Three Cases of Hip Joint Amputation by Wyeth's Method," by Dr. F. W. Parham, New Orleans; "Primary Endo-Mastoiditis, with Report of a Case," by Dr. H. J. Dupuy, New Orleans; "Surgical Aspects of Salpingitis; Electricity in Gynecology," by Dr. C. Jeff Miller.

THIRD DAY—*Morning Session.*—Upon opening the meeting the nominating committee reported the following names as recommended as officers for the coming year, and they were duly elected: President—Dr. F. W. Parham, New Orleans. Vice Presidents—First District, Dr. C. J. Landfried, New Orleans; Second District, Dr. J. Callan, New Orleans; Third District, Dr. C. M. Smith, Franklin; Fourth District, Dr. T. G. Ford, Shreveport; Fifth District, Dr. O. M. Patterson, Bastrop; Sixth District, Dr. R. C. Webb, Payen. Treasurer—Dr. H. S. Cocram, New Orleans. Recording Secretary—Dr. H. B. Gessner, New Orleans. Corresponding Secretary—Dr. A. G. Friedrichs, New Orleans.

Two names were selected for appointment to the State Medical Examining Board to fill vacancy in August: Dr. T. E. Schumpert, Shreveport, and Dr. T. N. Thornhill, of Arcadia.

On motion the following resolutions were adopted:

"Be it resolved, 1. That the society hereby create a special section, called the Section of Sanitary Science.

"2. That the local health officers of the State of Louisiana, who are members of the society, are hereby constituted ex-officio members of this section; and the health officers of the State who are not members of the society be requested to send in their applications for membership at once.

"3. That this section meet at 2:30 P. M. on the first day of each annual session.

"4. That the president of the State Board of Health be ex-officio chairman of this section.

"5. That when in the judgment of the society a special meeting may be necessary, the president of the society is hereby authorized to call special meetings of this society upon the request of its chairman.

"Be it resolved, 1. That the NEW ORLEANS MEDICAL AND

SURGICAL JOURNAL be made the official organ of the Louisiana State Medical Society.

"2. That a special committee be appointed to make arrangements for subscribing to the *Journal* for the society, in reference to terms, conditions, and be fully empowered to act in the premises."

Reading of papers then followed.

DR. FRED. J. MAYER, of Opelousas, for the Section on Quarantine, read an able paper on "Variola."

The following papers were then read: "The History and Treatment of an Ununited Fracture," by DR. T. E. SCHUMPERT, of Shreveport; "The Use of the Ice Bag in the Treatment of Pneumonia," by DR. J. M. BATCHELOR, of New Orleans; "Some Notes on Syphilis," etc., by DR. L. G. LEBEUF, New Orleans; "Interesting Case of Abscess of the Liver," by DR. A. WEBER, New Orleans; "Some Surgical Cases," by DR. E. H. WALET, New Orleans; "Maternal Impression, the Birth of Eight Albinoes, Four Full Developed, Four Anencephalous," by DR. P. B. MCCUTCHON, New Orleans.

Several resolutions were offered and passed:

By DR. MAYER, that the society recommend the establishment of a Department of Veterinary Medicine at the State University at Baton Rouge.

By DR. ARCHINARD (P. E.), that the Louisiana State Medical Society condemns the contract system for the treatment of contagious diseases in general, and especially the system in vogue in New Orleans at present, as inhuman and in direct contravention to all the recognized conditions of advanced civilization.

By DR. DYER, 1. That the society record itself as disapproving of the antivivisection bill now before Congress.

2. That the society urge the Louisiana delegation in Washington to take active part in securing some national health supervision.

By DR. PATTERSON: Resolution that the law providing for the creation of local boards of health be amended so as to permit physicians who have been living in a parish for one year to serve on the board. (The law at present makes the period of residence five years.)

A vote of thanks was tendered the Committee of Arrangements, the outgoing officers, the Medical Department of Tulane

University for the use of the rooms for meeting, to the Citizens' Protective Association for their attentions and entertainments, and to the daily press for their careful reports of the meeting.

The new officers were installed and the meeting adjourned, to repair at 1 o'clock to the St. Charles Hotel, where a delightful luncheon had been arranged by the Citizens' Protective Association. The Reception Committee of this body, consisting of Messrs. Winchester Bowling, A. L. Redden, B. Landau, J. P. Lewis, Joseph Collins and Julian Cohn, were solicitous in their attentions. After luncheon a number of the visiting members visited the State Fair, again meeting at 4 P. M., when a delightful ride around the city, to Audubon and City parks, was indulged in.

At 7 P. M. a special train conveyed the city and country members and a contingent of the Citizens' Protective Association to West End, where a fit ending was made to the most enthusiastic meeting the Society has had for many years. A feast of viands was intermingled with oratory and wit, and Lucullus vied with the philosophers until midnight brought the party back to the city. Dr. Andrew G. Friedrichs was the master of ceremonies.

DR. F. W. PARHAM, PRESIDENT-ELECT of the Louisiana State Medical Society for the year 1900-1901, has appointed the following committees:

Arrangements: Dr. Isadore Dyer, chairman; Drs. E. M. Dupaquier, John F. Oechsner.

Commiitees on Organization and on Necrology are *ex-officio.*

On Publication: Dr. H. B. Gessner, chairman; Drs. A. G. Friedrichs and H. S. Cocram.

On State Library: Dr. H. P. Jones, chairman; Drs. S. P. Delaup and Dr. W. L. Dickson, Shreveport.

On State Medicine and Legislation: Dr. H. D. Bruns, chairman; Drs. C. J Ducoté, J. W. Duprée, G. A. B. Hays, W. G. Owen, J. R. Fridge, A. A. Allain, T. S. Kennedy, John Callan, Chas. McVea, C. D. Simmons, T. G. Woolf, G. R. Fox, A. F. Barrow, F. J. Mayer.

On Judiciary: Dr. E. L. McGehee, chairman; Drs. Rudolph Matas, L. M. Provosty, J. J. Ayo, W. A. Holloway, Smith Gordon, Fred. J. Mayer, F. R. Bernard, Luther Sexton, F. J. Kearney, J. B. Gazzo, E. L. Erwin, Quitman Kohnke.

SECTIONS.—*General Medicine*: Chairman, Dr. W. G. Owen. To open discussion: Drs. T. S. Dabney and F. N. Thornhill. *Surgery:* Chairman, Dr. E. Denègre Martin. To open discussion: Drs. L. G. Sterling, Rudolph Matas, E. D. Fenner. *Neurology, including Mental Diseases:* Chairman, Dr. P. E. Archinard. To open discussion: Dr. E. M. Dupaquier. *Materia Medica:* Chairman, G. R. Folson. To open discussion: Drs. Luther Sexton, A. A. Allain. *Diseases of Children:* Chairman, Dr. J. D. Bloom, New Orleans. To open discussion: Drs. T. S. Kennedy, T. T. Tarleton. *Obstetrics and Gynecology:* Chairman, Dr. E. S. Lewis. To open discussion: Drs. P. Michinard, R. L. Luckett. *Ophthalmology*: Chairman, E. A. Robin. *Otology, Laryngology, Rhinology:* Chairman, Dr. O. Joachim. To open discussion: Drs. Wm. Scheppegrell, Gordon King. *Medical Jurisprudence:* Chairman, Dr. C. D. Simmons. To open discussion, Drs. S. L. Theard, E. D. Newell. *Dermatology:* Chairman, Dr. E. A. Blount. To open discussion, Drs. Isadore Dyer, J. N. Roussel, New Orleans. *Quarantine:* Chairman, Dr. J. N. Thomas. To open discussion, Dr. Felix Formento. *Bacteriology:* Chairman, Dr. John J. Archinard. To open discussion, Dr. O. L. Pothier. *Anatomy and Physiology:* Chairman, Dr. J. R. Fridge. To open discussion: Dr. John F. Oechsner. *Genito-Urinary Surgery:* Chairman, Dr. Chas. Chassaignac. To open discussion, Drs. W. K. Sutherlin, F. A. Larue. *Sanitary Science:* Chairman (*ex-officio*), Dr. Edmond Souchon.

Delegates to next meeting of American Medical Association. Members of the Society in good standing and intending to be present at the meeting of the American Medical Association will be appointed delegates on application to the Secretary, Dr. H. B. Gessner, 124 Baronne St., New Orleans.

THE SHREVEPORT BOARD OF HEALTH, through the chairman, Dr. J. C. Egan, has made a report on the vital statistics in that city for 1899:

The report shows total deaths of 395, in an estimated population of 26,000, or the exceedingly low rate of 1½ per cent. Of the deaths, 135 were whites and 260 colored, making the average deaths among the whites only nine in a thousand.

Dr. Egan, who is also vice president of the State Board of Health, is an efficient health officer, and it is due chiefly to his vigilance and skillful efforts that the sanitary conditions of Shreveport are in their present state of excellence.

The Eye, Ear, Nose and Throat Hospital, of New Orleans, held the annual meeting of directors in April. The annual report of Dr. A. W. de Roaldes, surgeon in chief, showed that during the year 5057 patients had been treated at the hospital. There was a daily average of 20 patients; 35,722 consultations were given, with an average of 127.12 patients daily; 721 opertions were performed; 998 patients from the State at large were treated during the year. Many of these cases had been neglected and were usually more serious incharacter and of longer duration.

The report further stated that the spreading reputation of this hospital naturally brings some of the worst cases; hence increased responsibility, which, instead of being met with adequate resources, coincides with a depleted treasury, the natural consequence of the non-payment of $7500 of city appropriation and the absence of legacies during the last four years.

This loss has been met by forced retrenchment, which has seriously affected the corps of resident surgeons and trained nurses and prevented urgent repairs, imperatively demanded for more than three years, the necessity of which is fully admitted by all.

Can such a condition continue without crippling the institution and leading to its final collapse? In the face of this state of affairs it is said as in a previous report, viz.: "The time is fast approaching when the trustees will have to consider seriously either the limitation of the charity or the question of making it a State institution. The trustees should now give this their earenst consideration and act for the best."

In considering the report, a committee was appointed to take up the serious question of the future of this worthy institution.

Tulane University has elected a President in the person of Prof. Edwin A. Alderman, formerly president of the University of North Carolina.

The Texas State Medical Association held an interesting and profitable meeting at Waco, April 24 to 27, under the presidency of Dr. A. B. Gardner, of Bellville.

THE PROGRAM OF THE AMERICAN DERMATOLOGICAL ASSOCIATION has been issued for the meeting to take place in Washington May 2 and 3. Some 27 papers are listed.

THE U. S. MARINE HOSPITAL SERVICE EXAMINATIONS will be be held in New York City, on Wednesday, May 23, 1900. Candidates for admission into this service must be between 21 and 30 years of age, graduates of a reputable medical college and must furnish testimonials of character. Physical, written, oral and clinical examinations are held. A circular of information has been issued by the supervising surgeon-general of the Marine Hospital Service, to whom all communications for information, etc., should be sent, at Washington, D. C., Marine Hospital Service.

THE WESTERN OPHTHALMOLOGIC AND OTO-LARYNGOLOGIC ASSOCIATION held the fifth annual meeting in St. Louis on April 5, 6 and 7. Among a number of papers read, the presiding officer, Dr. Wm. Scheppegrell, of New Orleans, read on "The Rise of Specialism." The meeting was quite successful.

The officers elected for the ensuing year were as follows: Dr. M. A. Goldstein, of St. Louis, president; Dr. Wurdemann, of St. Paul, first vice president; Dr. C. R. Holmes, of Cincinnati, second vice president; Dr. Fayette C. Ewing, of St. Louis, third vice president; Dr. W. L. Dayton, of Lincoln, Neb., treasurer; Dr. Wm. L. Ballenger, of Chicago, secretary. Dr. C. R. Holmes, of Cincinnati, was made chairman of the local committee of arrangements for the meeting to be held in Cincinnati next year, and Dr. Loeb, of St. Louis, chairman of the membership committee.

THE JOURNAL acknowledges receipt of a very dainty invitation and announcment of the Medical Committee of the United Confederate Veterans, Louisville Reunion, to take place May 30, 31 and June 1, 2 and 3.

THE JOURNAL wishes to correct an error in the April number, referring to the treatment of diabetes mellitus. The lines should read, "The article concludes with the argument that the bromides of gold and arsenic," instead of "gold and sodium," act by saturating the system.

The American Medico-Psychological Association will meet in Richmond, Va., May 22–25, 1900. A preliminary program has been issued by the secretary, Dr. C. B. Burr, Flint, Mich.

Personal.—Dr. W. T. Williams has located at Natchitoches, La., after post-graduate work; he was formerly at Montgomery.

Dr. L. Aderson has moved from Port Gibson to Biloxi, Miss.

Mortuary.—Dr. J. M. Folwell, a well-known physician in New Orleans, died March 31, 1900, at an advanced age.

The Annual Meeting of the Mississippi State Medical Association, to have been held at Meridian, has been postponed to May 16, 17 and 18 on account of the floods.

The Attorney General of the State of Texas instituted *quo warranto* proceedings against the New York Medical College of San Antonio for forfeiture of charter, and to restrain the concern from issuing diplomas for the practice of medicine. This "college" was incorporated for the purpose of teaching medicine by mail or otherwise. Its diplomas in the State are valid in law, but the complainant avers that "the main object and practice of the defendant is to sell its diplomas to any person it pleases, whether informed or not in the science of medicine, for the stipulated sum of $50." Specific charges made. Good for Texas!

Book Reviews and Notices.

All new publications sent to the Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Essentials of Anatomy, arranged in the form of Questions and Answers, prepared especially for students of Medicine. Edited by Chas. B. Nancreed, M. D., and revised by Fred. J. Bockeray, M. D. W. B. Saunders, Philadelphia, 1900.

This little book is no stranger to the profession. The sixth edition has just been published. It is all the author claims for it, being essentially a work of anatomy, not simply a compend of anatomical names.

The cuts are clear and add much to the value of the book. This edition has been thoroughly revised and as now published will not only prove a great assistance to the student, but an aid to the physician.

MARTIN.

Notes on the Modern Treatment of Fractures. By JNO. B. ROBERTS, M. D. D. Appleton & Co., New York, 1900.

Although some of the suggestions made by the author in this treatise are radical and can only be attempted by a competent surgeon, yet we are struck by his boldness. We fully agree with him that the treatment of fractures requires the exercise of the greatest amount of common sense, rather than a blind reliance upon therapeutic dogmas and adoption of routine methods.

It is refreshing to read something out of the ordinary; something truly original.

The author deals mostly with special fractures and the mooted questions of the day in regard to treatment, especially as to operative interference.

Every chapter is full of original ideas and common sense treatment.

MARTIN.

A Manual of Surgery for the Use of Students and Practitioners. BY JOHN B. ROBERTS, A. M., M. D. Second Edition, Revised and Enlarged. Lea Brothers & Co., Philadelphia and New York, 1899.

This second edition of Roberts' work has been brought up to date by the re-writing of subjects which have specially felt the impress of the great surgical activity marking the period intervening since the first edition appeared. The whole text has been carefully revised. The carefully prepared index is a special feature of the book. The most serious criticism of the book is the lack of adequate reference to conditions that depart from the typical; but what is stated, is clearly stated, and may be accepted by the student and practitioner as a reliable guide and expression of the latest surgical advance.

PARHAM.

Lectures Upon the Principles of Surgery, by CHAS. B. NANCREDE, A. M., M. D, LL. D. With an appendix containing the principal views held concerning inflammation, by WM. A. SPITZLEY, A. B., M. D. Illustrated. W. B. SAUNDERS, Philadelphia, 1899.

This work consists of thirty-six lectures delivered by Nancrede, and an appendix giving a resumé of the different views held at various periods concerning inflammation. These lectures will, we feel sure, prove very valuable to students in acquiring a proper conception of inflammation and the principles of surgery. At the outset he draws very strongly the distinction between inflammation and the process of repair, maintaining that "inflammation is never anything but an infective process." The views held throughout these lectures are sound, and the clear and simple manner in which they are presented can not fail to make the book very acceptable to students of medicine. Some few inaccuracies in the statement of practical details such as in the Schleich formulae on page 367, which have been very carelessly written or printed, might be noted, but the excellencies so far outnumber the faults that we can heartily commend the book to all students of medicine and to practitioners who desire to review the principles of surgery. The style is attractive, the views modern, the type easy and the size of the volume very convenient for reading.

Parham.

A Manual of Surgery, By Charles Stoneham, F. R. C. S., England, in three volumes. The Macmillan Co., New York.

The object of this work, as stated in the preface, is "to give a succinct account of modern surgical pathology, diagnosis and treatment, and it is intended as a manual for practitioners and students." This object has been well carried out by one who has for many years been connected with the hospitals of London and has been examiner in surgery, so that he has had abundant opportunity to familiarize himself with the needs of students. The work gives a very fair presentation of modern surgery. While it cannot in any manner be said to be superior to any one of several late works on surgery, still as embodying the views of a surgeon of sixteen years' hospital experience, it will have its place in the surgeon's library. We think more stress should have been laid upon the difference between the processes of inflammation and repair. The author seems to consider the difference one of degree rather than an essential one. While he argues clearly for the important role played by the infective bacteria and lays the proper stress upon the necessity of keeping them out of the wound, still it is not in accordance with the most advanced views of inflammation and repair to consider them practically identical, and the student would be much more forcibly impressed if the distinction between the processes were made more striking. The truth is, while the processes are similar, they are not identical, and the differences should be clearly shown. The three small volumes are of handy size and will prove very convenient for reference.

Parham.

PUBLICATIONS RECEIVED.

The Technique of Operative Surgery, by J. L. Johnson, M. D.—Courier Journal Job Printing Company, 1898, Louisville, Ky

The International Medical Annual and Practitioner's Index, by Wm. Murrell, M. D.—E. B. Treat & Co., New York and Chicago, 1900.

Serum Therapy, published by the Scientific Department of Frederick Stearns & Co., Detroit, Michigan.

Proceedings of the Philadelphia County Medical Society, published by the Society, Philadelphia, Pa., 1900.

Essentials of Surgery, by Edward Martin, M. D.—W. B. Saunders, Philadelphia, 1900.

Progressive Medicine, Edited by Hobart Amory Hare, M. D., and Charles Adams Holder, M. D., Vol. I, March, 1900.—Lea Bros. & Co., Philadelphia and New York.

Elements of Clinical Bacteriology, by Dr. Ernest Levy and Dr. Felix Klemperer.—W. B. Saunders, Philadelphia, 1900.

Report of the Board of Administrators of the Charity Hospital, 1899.

Diseases of the Stomach, by John C. Hemmeter, M. D.—P. Blakiston's, Son & Co., Philadelphia, 1900.

Bulletin of the Harvard Medical Alumni Association.—Boston, 1900.

Report of the Kensington Hospital for Women, Philadelphia, Pa.

Injuries to the Eye in their Medico-Legal Aspect, by S. Baubry, M. D.—The F. A. Davis Company, Philadelphia, New York and Chicago, 1900.

The Anatomy of the Brain, by Richard H. Whitehead, M. D.—The F. A. Davis Co., Philadelphia, New York and Chicago, 1900.

Twentieth Century Practice of Medicine, Edited by Thos. L. Stedman, M. D.—William Wood & Co., New York, 1900.

Cyclopedia of Medicine and Surgery, George M. Gould, M. D., and Walter L. Pyle, M. D.—P. Blakiston's Sons & Co., Philadelphia, 1900.

REPRINTS.

Subconjunctival Injections in Certain Diseases of the Eye.—Notes on Some Recent Eye Cases in Railway Practice, by Dunbar Roy, M. D.

The Diagnosis of Gastric Ulcer, with Report of Cases, by Frank H. Murdock, M. D.

Stricture of the Esophagus and Electrolysis by a New Esophageal Electrode, by Charles D. Aaron, M. D.

The Justo-Major Pelvis as a Factor in the Causation of Perineal Injuries, by Joseph Brown Cooke, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Bulletin of the Board of Health of the City of New Orleans.)

For March, 1900.

CAUSE.	*White.....*	*Colored...*	*Total.....*
Fever, Malarial (unclassified)	1	3	4
" " Intermittent	....	....	....
" " Remittent	1	1	2
" " Congestive	1	....	1
" " Typho	1	2	3
" Yellow	....	....	....
" Typhoid or Enteric	4	2	6
" Puerperal	....	....	....
Influenza	7	2	9
Measles	5	3	8
Diphtheria	1	1	2
Whooping Cough	....	....	....
Apoplexy	9	1	10
Congestion of Brain	4	2	6
Meningitis	14	3	17
Pneumonia	69	31	100
Bronchitis	16	8	24
Cancer	18	4	22
Consumption	46	44	90
Bright's Disease (Nephritis)	25	14	39
Uremia	....	....	....
Diarrhea (Enteritis)	5	2	7
Gastro-Enteritis	1	1	2
Dysentery	....	1	1
Hepatitis	3	1	4
Hepatic Cirrhosis	6	2	8
Peritonitis	2	3	5
Debility, General	3	2	5
" Senile	17	12	29
" Infantile	3	6	9
Heart, Diseases of	31	24	55
Tetanus, Idiopathic	....	....	....
" Traumatic	1	1	2
Trismus Nascentium	4	3	7
Injuries	11	10	21
Suicide	1	1	2
All Other Causes	85	107	192
Total	395	297	692

Still-born Children—White, 14; colored, 15; total, 29.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 22.57; colored, 39.60; total, 27.71.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.08
Mean temperature	61.
Total precipitation, inches	4.

Prevailing direction of wind, north.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

Vol. LII. JUNE, 1900. No. 12.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

SOME RECENT HISTORY OF SMALL-POX IN NEW ORLEANS.

By Dr. QUITMAN KOHNKE, Health Officer of the City of New Orleans.

A request from the Chairman of the Section on Quarantine of the State Medical Society, addressed to the health officer of a city, containing small-pox, for a history of the disease at the time existing, can not but have the force of a command, however gently communicated, and a prompt obedience is the only proper response.

There is much that is interesting in the history of our recent and still existing misfortune, and a study of the situation and its causes has not been uninstructive.

The figures and statements submitted are based upon the records of the Board of Health and information obtained by the officers and employees of the Board in the daily discharge of their duties.

The first case of small-pox in New Orleans, during 1899, was discovered on February 2, in the person of a negro steamboat laborer from Cincinnati.

Following this imported case came others from the same and other sources in increasing numbers, and these mingling, before discovery, with our people of the same class, soon gave rise to infection, whose immediate origin could not be traced to outside sources.

Prompt isolation of cases as they were discovered, thorough disinfection of premises containing infection and extensive vaccination of infectable neighborhoods, succeeded in controlling the disease by preventing its spread, and the last of 232 cases occurred on July 24, 1899.

Of these 232 cases, 110 were traced to sources of infection outside of the city; many being brought here during the eruptive stage of the disease, each case being a possible focus of infection. No less than nine States contributed patients to our small-pox hospital, and forty-two localities in Louisiana sent us subjects for our charity. I do not intend to say, merely, that residents of nine States and forty-two localities in Louisiana were treated in this city, but that these people arrived in New Orleans from their point of departure within the period of incubation; many of them, as I have said, arriving in the eruptive stage.

Under these circumstances, it may be mentioned with pardonable pride, I hope, that only 122 .cases developed in this city; and with gratification, that, of the 232 cases, only five ended in death. All, but one, of these cases received treatment at the small-pox hospital, with a mortality of a fraction more than two per cent.

On July 30, August 12 and August 26, cases were imported, but prompt isolation prevented infection, and no case of small-pox existed in the city other than these until October 20, when a negro arrived in the city from Kenner, La., with the eruption of variola plainly showing on his face.

Closely following this came others from the same and from other localities, which were taken charge of as soon as discovered, the disease being kept fairly well in hand until, as a result of repeated inoculations by imported cases, both in the incubative period and the eruptive stage of variola, the Charity Hospital became infected. The first inmate of the Charity Hospital to contract the disease was taken out of that institution on December 7, having been there since October 12, from Plaquemine. The measures of prevention were evidently successful, for no case developed in the Hospital during the following three weeks. On January 3 a case developed in the person of an old inmate of the institution. The next day another case was discovered, and on the 5th still another, whose origin seemed to be infection within the hospital.

A period of quiescence followed corresponding to the usual period of incubation, at the termination of which on January 17 a large number of cases developed simultaneously, forty-two out of fifty-one wards of the hospital furnishing cases at about the same time.

Small-pox in New Orleans had, up to this unfortunate development, seemed fairly well under control, save that fresh importations into the city could not be prevented; these, however, were quickly discovered and promptly isolated. The great calamity was the infection of the Charity Hospital, an institution containing a daily average of 586 resident patients, receiving visits, additionally, of 224 out-patients per day, to say nothing of the number of employees and of visitors to the sick.

How was the hospital infected? Most certainly by the repeated introduction of small-pox patients into the city from the surrounding country.

Among the first thoughts that occur to a sick negro seems to be one that directs his footsteps to the Charity Hospital, and, though he be removed a hundred miles or so from the city, he usually finds no great difficulty in getting transportation. The interval of time between the initial manifestation of disease and the appearance of the eruption is amply sufficient to include a day's travel and the slight delays incident to admission to the hospital, and, despite every effort to prevent it, some small-pox patients, at least, must have gained admittance before a diagnosis could be made, and from this to serious infection of the hospital was natural and easy.

The Charity Hospital does not, of course, treat small-pox; but this is known to the patient, apparently, only after his arrival in the city, and his failure to obtain admission to the hospital.

A study of the small-pox situation with regard to the Charity Hospital is interesting and instructive, and indicates clearly the necessity of protecting this institution and the lives of its inmates against a recurrence of the unfortunate series of accidents that resulted in the temporary closure of its doors to the suffering poor until its wards were thorougly disinfected and its functions of relieving physical distress could be resumed with safety.

During the period between December 7, 1899, when the first case of variola developed, which originated, apparently, in the Hospital, and February 20, 1900, the date of the last, seemingly, of that series of cases of similar origin, there were removed to the small-pox hospital, from the Charity Hospital, 136 patients; 75 of these were inmates as patients or employees at the time they contracted variola, that is to say, they were inmates of the Hospital for more than 14 days prior to the observation of diagnostic symptoms. Of the other 61, most, if not all, of them applied for treatment and were immediately removed to the small-pox hospital; 20, only, of these 61, contracted variola in New Orleans; and of the remaining 41, three-fourths, at least, were in the city less than one day, indicating plainly that neighboring parishes were unloading upon the city.

This unloading process, while it seemed like a deliberate attempt on the part of our neighbors to rid themselves of a disagreeable and costly burden, was probably nothing more than the normal influx to the Charity Hospital of the sick from the surrounding country, made more noticeable by the objectionable character of the disease and the necessity of prompt removal of the cases, as soon as discovered; the Charity Hospital having no isolation ward for even the temporary housing of small-pox; a mistake, in my opinion, of very serious import.

First case of present series of variola cases was reported October 20, 1899. First death occurred December 31, 1899.

Number of cases from October 20, 1899, to April 12, 1900, inclusive, 924. Number of deaths, same period, 232.

Number of cases treated at small-pox hospital, October 20, 1899—April 12, 1900, inclusive, 619; in residences, 305; total 924. Number of deaths at small-pox hospital, same period, 172; in residences, 80; total 252.

Number of patients remaining under treatment on the morning of April 13, 1900, at the small-pox hospital, 66; in residences, 76; total 142.

Percentage of deaths among cases in which result has already been ascertained (924-142), 32.22. For the small-pox hospital, 31.10; for residences, 34.93.

It will be noticed that the mortality in the early part of 1899 was very low, a little more than two per cent., while for the series of cases that began later in 1899 and extended into 1900, to the present time (April 13), the mortality is very high, nor can this marked difference in mortality be ascribed to any known cause other than the severity of the type.

The methods of prevention in operation in New Orleans, briefly stated, are these: Upon the discovery of a case, the patient, if unable to procure the necessary attention elsewhere, is immediately removed to the small-pox hospital, in a vehicle which is subsequently thoroughly disinfected by the liberal use of a solution of bichloride of mercury in water (1 to 500). The room from which he has been removed is also disinfected. If the patient is able to procure proper attention at home, the house is quarantined, and according to the reliability of the family or other inmates, and according to the ability of the Board of Health to pay for the service, the house is guarded day and night, by day only, or visited daily. Of course, vaccination is urged in every possible way and practiced on all who will submit.

The house or portion of house is invariably indicated as infected by the placing of a placard in such a manner as to be plainly visible to any one before entering. Bichloride solution is furnished, with instructions for its use, and strict isolation is advised, enjoined or enforced, according to the character of the people affected, their intelligence and their willingness to comply with the requirements; and also, again, according to the ability of the Board of Health to pay for the service.

In case of death, sanitary inspectors are immediately dispatched to the house and the body is thoroughly saturated with bichloride solution and wrapped in a sheet, soaked in the same, and, as soon as possible, the body so wrapped is placed in the coffin, previously saturated with the solution, which is immediately closed. The funeral takes place as soon as possible and always on the day of death, unless this occurs too late in the evening, when the interment is required the next morning. The funeral is private, and the coffin is handled entirely by sanitary inspectors, who also disinfect the hearse and the carriages possibly infected.

The room or rooms of the house infected are, after being sealed by pasting paper strips over all cracks between openings and their frames, subjected to the fumes of sulphur, using five pounds to each 1000 cubic feet of air space, and, after an average of about fourteen hours' fumigation, the floor, part of the walls and the wood-work are washed off with the bichloride solution, and every portion of the house also that is likely to be infected.

No hard and fast rules can be laid down which will apply to every house, but the general directions are issued and are executed with judgment and tact, keeping in mind, always, the object desired—the prevention of infection—by the destruction of morbific material. The bed clothes, mattress and all textile fabrics which are infected are destroyed by fire or submitted to boiling for an hour or more, or soaked in bichloride solution; at times all of these methods, in addition to sulphur fumes, are applied to the contents of a single room.

The same methods of disinfection are operated in premises after the sanitary discharge of a patient as after a less fortunate termination; but here we have a factor to deal with in regard to which opinions seem to be at serious variance. When should the sanitary discharge of a convalescent patient take place? Shall the period of detention be measured by time or marked by condition? If by time, then what time? if by condition, then what condition? Our experience is that time can not properly indicate the period of quarantine in all cases, and, while three weeks may be considered the average duration of infection, many cases are free of this danger in less time, and not a few require much more; an instance of the latter having been a short while ago called to my attention in a strikingly forcible manner. A patient applied for admission to the Charity Hospital, who had to be removed from a baggage car and transported to the hospital in a city wagon. This poor fellow's foot was gangrenous and he was covered with scabs of small pox, but armed with a certificate signed by the health officer of a town in Louisiana that he had been properly discharged and should not be considered a possible source of infection. This health officer, it is charitable to believe, did not see the patient, but judged that, the usual period of time having elapsed, freedom from morbific material must have been obtained. The patient referred to was taken to the small-pox hospital on March 10, 1900, in a condition of great prostration and later died from variola and septicemia, having received, before contracting small-pox, a surgical injury for which he desired treatment at the Charity Hospital.

The following circular is sent to every physician who treats a case of scarlet fever or small-pox in New Orleans:

"SCARLET FEVER—VARIOLA.

"*To the Attending Physician:*

"DEAR DOCTOR—The interval of time between the clinical recovery and the termination of the period of infectiousness in Scarlet Fever and Variola being usually quite long, the attending physician is requested to advise this office of the recovery of his patient, whereupon the Board of Health will assume sanitary charge of the case and determine, through its officer, the date of disinfection, subject, always, to the co-operation and advice of the medical attendant, should he so desire.

"Respectfully, QUITMAN KOHNKE, M. D.,
"*Chairman and Health Officer.*"

Usually, the attending physician prefers to clinically discharge his patient and refer the convalescent to the health authorities for sanitary supervision, in which case a medical officer visits the house as often as may be necessary to determine the earliest moment of sanitary release. This has not arrived, in my opinion, until the last scab has fallen and the skin is free from those presumably infected particles of tissue which have been in immediate proximity to the contents of a pustule.

The portion of the surface from which the infectious material is thrown off latest is, usually, the sole of the foot, through the thickened epidermis of which the pustule seldom breaks, and the resultant dried brown spot slowly works its way and frequently is picked out with a knife or scissors' blade. Until the last brown spot, which is nothing more or less than a dried and unbroken pustule, has disappeared, danger of infection from the patient should be considered as present, and while we do not know enough of variola to recognize a specific germ as a causative influence, analogous knowledge convinces us that this must be a germ disease, and actual experiment proves that the residence of the germ is in the local manifestation—the papule, vesicle, pustule or scab. There remains to be considered, then, the life of virulence in the scab. How long does the scab of cow-pox retain its property of inoculation? Certainly longer than the longest possible period of quarantine; and what is demonstrable, in this respect, of cow-pox should be accepted as true of small-pox.

If the brown spots on the palms and soles are dried pustules (and there can be no doubt that they are) we should insist that isolation of the convalescent from the susceptible should be maintained as long as these spots remain. This is a simple proposition and is, to my mind, convincing, but great difficulty is frequently experienced in prevailing upon patients to consider an innocent looking little discoloration a source of danger, and fourteen to twenty-one days' detention is a very irksome requirement to one who does not understand the necessity for such a measure of precaution, and still more irksome for one who is not interested in anything but his own welfare.

The majority of the small-pox cases have been and generally are among the lesser informed and are difficult to deal with on this account.

Small-pox among the well-to-do and intelligent does not spread; nor does it gain a foothold in a community that is ready and willing to pay the cost of prevention which, however expensive, is placing human life at its lowest money valuation, a measure of economy, and, therefore, desirable even from a sordid business point of view.

VIVISECTION IS A NECESSITY FOR MEDICAL PROGRESS.*

BY S. P. DELAUP, B. SC., M. D., VISITING SURGEON TO CHARITY HOSPITAL; CLINICAL ASSISTANT TO THE CHAIR OF GENITO-URINARY AND RECTAL DISEASES IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS.

In view of the fact that Congress is about to act on the Anti-vivisection Bill, I have deemed it timely and proper to offer for discussion this most important question.

In the question discussed, the medical profession is practically unanimous in its opinion of the harmfulness of the pending measure. The measure was formerly entitled "A Bill for the Further Prevention of Cruelty to Animals in the District of Columbia," but before the present Congress it reappears under a new title, "A Bill for the Regulation of Scientific Experiments in the District of Columbia," and it is in this harmless guise that the Humane Society of Washington is endeavoring to usurp to itself the power of controlling all animal experimentation, not only in the Government laboratories, but also in those of the medical schools and of private individuals. The advocates of the bill are most specious in their arguments in favor of abolishing imaginary cruelties of a most horrifying character and preventing their occurrence by means of carefully issued licenses, and a system of regular and irregular inspection.

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*Read before the Louisiana State Medical Society, April 20, 1900, as Chairman of the Section on Anatomy and Physiology.

The harmful character of the bill, as an entering wedge in the hands of visionary enthusiasts, destined to prevent all animal experimentation, and so striking at the root of all progress in organic medicine, has been clearly pointed out by the scientific members of the medical profession resident in the city of Washington. This view of the measure has been confirmed by numberless memorials to Congress from all the prominent medical and scientific gatherings which have convened in this country for the last three years, and yet the measure is constantly gaining in strength and steadily approaching the goal of its final passage.

The crusade of the anti-vivisectionists, from beginning to the end, has been a series of equivocations, misrepresentations and half truths. Scientific experimenters of the world are directly charged with brutal, inhuman and cruel conduct towards animals, in carrying out their experiments and investigations. Physicians are charged with being participators or accomplices in these so-called atrocities, and it is claimed that no real advance in medical knowledge, which could not have been made without it, has followed as a result of vivisection.

The charge that physicians, without sufficient cause, sanction wanton or cruel treatment, or animal mutilations and sufferings which are unnecessary, is a gratuitous insult to a profession animated by the most self-sacrificing and humane instincts of any class of people in the world, a profession which has done more to alleviate human suffering, stay the devastations of plague, disease and death, to discover and demonstrate the laws of health and causes of diseases, and raise mankind to a higher and better plane, in short to advance civilization, than all other influences combined.

When these facts are appreciated I believe all fair-minded people will concede that the medical profession is animated by noble and disinterested motives; that its vivisections and all other investigations and experiments are made in the interests of science, truth and humanity, and not, as has been charged, for the mere sake of performing experiments.

The object of all these scientific investigations is to find out the causes of things, and it was only when inductive science came and put intelligently planned experiments in the place of haphazard experience that a single advance was made. On the principles and truths thus discovered by experimental investigations, the splendid results of our modern scientific knowlege and inventions, our progress in medicine, surgery and sanitary science almost entirely depends.

We who live under the benign influences of modern sanitary surroundings can not realize the benefits we enjoy until we compare the results of thousands of years of empyric experience with the actually remarkable achievements of experimental science, especially the application of the laws of health as demonstrated by vivisection experiments. We no longer behold plague and pestilence sweeping over the land, leaving desolation and death in their track, nor do meet with such ravages as were formerly caused by small-pox. Still we are challenged by the hypercritic, hypersensitive and, I might say, hysteric advocates of a measure which is designed to be the entering wedge of a system of espionage, surveillance and obstruction to experiments made on living animals; a system that would place the lives of a few dogs, cats, guinea pigs or other lower animals above science, truth and the lives of thousands of human beings, for however much some of the advocates of the pending measure may try to conceal their real intentions, yet their avowed purpose, as boldly announced by others, is the entire suppression of all vivisection. If the bill passes Congress, experimental science in this country will be handicapped just as it is now in England where many scientific workers, including Lord Lister, one of the greatest benefactors of the human race through his introduction of antiseptic surgery, have preferred to leave their country and conduct their experiments in Continental laboratories, rather than submit to the vexatious restrictions upon their work.

The constantly reiterated statement of antivivisectionists that animal experimentation has been of little or no value to medicine can be the result only of ignorance, or of wilful misrepresentation. As Dr. Welch, of Johns Hopkins University, eloquently says (*Journal Am. Med. Ass'n*, Vol. XXX): "It would be surprising, indeed, if the experimental method, which is essential to every other science and has been the great instrument of modern scientific progress, should have no value for medical science. Surely this is a matter concerning which the judgment of the great body of enlightened physicians should be decisive. The progress of medicine from the time of the discovery of the circulation of the blood, which was based upon the results of animal experimentation, up to the present time, has rested in very large measure upon discoveries which could have been made only by experiments upon animals."

It must suffice here to cite only a few illustrations of the practical value of animal experimentation, and for these I must acknowledge my indebtedness chiefly to Dr. Stuver's excellent article on this subject (*Journal Am. Med. Ass'n*, Vol. XXX).

By the vivisections of Malpighi, Waller and Cohnheim we learned how blood nourishes the tissues; by the animal experiments of Aselli and Recquet, how the chyle is carried into the blood. The processes of intestinal digestion were revealed by the vivisections of Hunter, Magendie and others.

Sir Charles Bell and Magendie in the same way discovered the difference between the motor and sensory functions of the spinal nerves, and the experiments of Ferrier and a host of others have so illumined the physiology of the brain and localized its functions that many things which were dark and mysterious a few years ago are now as clear as the noonday sun.

For thousands of years, under the regime of empyricism, men continued to breathe and rebreathe foul and poisoned air. By living in close and badly ventilated buildings they intensified mild diseases into pestilences, and then explained the result as a scourge of the Almighty for a lack of fealty to their faiths.

In 1674 John Mayow, a young Oxford physician, became skeptic of the prevailing doctrines and, defying society's prohibition of experimentation on animals, proceeded to find out how animals breathe. By the painful, slow, suffocating to death of a few animals in airtight jars, Mayow demonstrated that the agony and death of a suffocated animal were due to the consumption of a constituent of the air.

As soon as these facts were known, the old superstitious notions of disease being caused by ghosts and demons vanished in air, and the results of the sacrifice of a few mice, the wanton, brutal torture it might be called by some, came with healing wings to banish slow poisoning, torture and death from millions of homes. Later on, Black, by the aid of more experiments on animals, discovered the effects of carbonic acid gas. Priestley in the same way demonstrated the life-giving quality of his oxygen, and Rutherford and Lavoisier followed the same course in proving that nitrogen would not support life. Thus we see that the foundation stones of modern chemistry were laid by this kind of vivisecting.

But it may be asked, is this all that vivisection has done?

The results of the experiments of Pasteur caused Lister to investigate the influence of antisepsis in the treatment of wounds. This has led to our modern antiseptic treatment which has saved thousands of lives and untold suffering, besides bringing surgery to a degree of perfection undreamed of a few years ago.

One of the most signal and conclusive examples of the great value of animal experimentation is the splendid success of the antitoxin treatment of diphtheria, especially in that deadly form affecting the larynx.

We might in this manner continue indefinitely to cite more illustrations and proofs of the practical value of animal experimentation, but we fear these introductory remarks have already reached more than their intended length. We will, therefore, summarize a few more illustrations and recall to your mind the establishment of the germ theory of disease, the prevention of child-bed fever, the antitoxin treatment of diseases other than diphtheria, the prevention of rabies by Pasteur's method of inoculation, the successful treatment of myxedema and cretinism by thyroid extracts.

Countless thousands of human lives have been saved and will continue to be saved by methods of prevention and treatment of disease which are derived from results of animal experimentation. Recent years have been particularly fruitful in discoveries of the highest importance resulting from animal experimentation. Never was there so little justification to hamper in any way the work of those engaged in searching by experiments for means of preventing and curing diseases. We thus see that nearly all our knowledge of physiology, much of that in chemistry, and many of the greatest advances in curing or stamping out diseases have resulted directly from vivisection.

THE ANNUAL REPORT OF 1900 TO THE PRESIDENT OF THE TULANE UNIVERSITY OF LOUISIANA, AT THE ANNUAL COMMENCEMENT OF THE MEDICAL DEPARTMENT, MAY 2, 1900.

BY PROF. STANFORD E. CHAILLÉ, M. D., DEAN.

MR. PRESIDENT—During the past year several events have occurred deserving record in the history of our college.

Although this is the 15th Commencement that I have served as Dean of the Medical Department, yet this is the only one saddened by the absence of my dear friend, Wm. Preston Johnston, the distinguished, the beloved, and the first President of Tulane University. His term of service began January 16, 1883, although the Tulane University of Louisiana was not finally established by law until July 5, 1884, and closed with his death July 16, 1899.

Many eloquent tributes to his memory have been published, amply justified by his merits as a gentle and a noble man by nature's bounty as well as by hereditary descent, as a sterling patriot of the South, as an author and poet of distinction, as the admirable organizer of Tulane University and as one of the greatest of the educational leaders of the South. In every one of many instances his aid and influence, when solicited by the Medical Faculty, were given promptly and cordially, so that our Faculty has lost in him not only a wise executive of the University, but also a zealous friend to the Medical Department.

But memorable as are his good deeds, still dearer to his friends is the memory of his presence and his character; so simple, unpretentious, unselfish, considerate and manly, that he inspired in all who knew him implicit trust and loving esteem. First acquainted with and attracted by him in 1863, when both were officers in the Confederate army, many years of friendship bound us together; and though we often engaged in discussion and sometimes disagreed, yet no word or act of his ever tarnished the luster of our friendship or now needs the charity of forgetfulness.

Unfortunately for mankind, nature rarely begets such a lovable combination of woman's tenderness with man's strength as were united in him—very rarely one of whom it can be said so truly that "even his failings leaned to virtue's side."

His devotion to duty and the good done by him, his nobility of character and sweetness of disposition, the many griefs he patiently suffered and the bodily pain he endured so long and manfully, justify my conviction that if any man's life ever merited such reward, then did Wm. Preston Johnston deserve to be awakened from the sleep of death by God's welcoming words:

> "Here bring your wounded heart, here tell your anguish;
> Earth has no sorrow that Heaven can not heal."

At our last commencement Prof. Edwin A. Alderman, president of the University of North Carolina, was our annual orator, and to this event it was due that the last social entertainment ever given by President Johnston was in honor of him who is now president elect of Tulane University. The warm mutual regard then established enhances the welcome that every department of the University will extend to President Alderman, who will receive from none more cordial support and hearty co-operation than from the Tulane Medical Faculty.

This day closes the sixty-sixth year of the existence of our college, and our graduates now number 3401 in medicine and 316 in pharmacy. As to the number of our students, the last session gained forty-four over the preceding session, and the present session has made an additional gain of thirty-eight students; so that the Dean is enabled to announce the very gratifying fact that the total number of students was 426, the greatest number in the history of our college. The previous maximum number was 420 in 1893. At the following session evidence of preliminary education, and three instead of two years' attendance were required, and thereby every student was forced to expend more time and money to complete his medical education, at the very time when the financial condition of the southwest was not prosperous. For these reasons the number of students annually attending was so seriously diminished that it has taken the seven years, from 1893 to 1900, to adjust the college to its new conditions and to regain our annual losses.

Four instead of three years' attendance was for the first time required at the present session of all students entering the first year's course; and, while there has been a very great increase in the number of our second and third year students, all of whom are entitled to be graduated at the end of their third year, the number of our first year students has so notably decreased that there is good reason to fear that the total number at our next session will be much fewer than 426, and that some years will be required to regain the losses inflicted by the requirement of four years' attendance.

The increased attendance at the present session has been due chiefly to two causes: The augmenting repute of our college for its superior practical advantages, and the very great improvement in the price of cotton, on which the prosperity of the Southwest most depends.

A contributory cause was the postponement in 1899, as in 1897 and 1898, of the opening of the present session on account of the very numerous yellow fever quarantines established against New Orleans. Whenever quarantines are imposed, even if unjustifiable, very grave fear is aroused among those for whose protection non-intercourse has been officially commanded. Our postponement calmed the fear of very many anxious parents, inspired their confidence and induced them to persist in sending their sons to our college, rather than to any one of very many other medical colleges that are both cheaper and more accessible. Inasmuch as other educational institutions of our city did not defer the opening of their sessions, our postponement was criticised very unfavorably, notwithstanding the fact that the conditions influencing our college and other colleges and schools in New Orleans differ in two very important particulars. First, a medical faculty is rightly held to greater responsibility as to disease than is a non-medical faculty; and second, our college attracts many more and is far more dependent on non-resident students than is any other college or school in this city, for more than two-thirds of our students are non-residents, and those attending the present session have come to us from seventeen States.

This session has been sadly notable for an exceptional and deplorable outbreak of disease among our students. On January 18, it was feared, and on the 19th it was first known that three students had been attacked by small-pox. By Monday, the 22d, the number had increased to twelve, and there were many reports justifying fear that others had been or would be attacked. Prompt measures were at once adopted to stamp out the disease by the vaccination and revaccination of every student, and by the isolation of the sick in a building under the control of the faculty.

No interruption occurred in the curriculum of studies, except in the daily visits to the Charity Hospital, where the disease had been contracted from infected patients, but contracted prior to the knowledge that the sickness of these patients was due to small-pox Not only were all these patients removed from the Charity Hospital as promptly as the nature of their disease could be determined, but the infected wards were again and again disinfected, and students, as also all other visitors, were excluded until safety was assured, as was done by February 2.

Three students, of whom two died, were cared for by their families at their homes; the nine others were taken charge of and isolated by the Faculty and, in the meantime, all students were thoroughly vaccinated. The gratifying result was that not a single case occurred after the first outbreak of twelve cases, and, of the nine students isolated in the Faculty's hospital only one, who was desperately ill when admitted, died. The charge of our hospital was given to Dr. P. E. Archinard, who was zealously assisted by Dr. J. J. Archinard, and to these two was chiefly due the very faithful, capable and successful management of hospital and patients, during the thirty-four days this hospital was required.

The students of several other colleges have also suffered during the present widespread epidemic, that has afflicted many hundreds of communities in not less than forty of the fifty-one States and Territories of the United States. Manifestly the vaccination and revaccination of all students on their admission to every college would be a wise precaution.

The distressing outbreak of disease among our students and the diminished number attending the first of the four years, now required for graduation, were the only incidents that marred the great gratification due to the otherwise unprecedented prosperity of the present session.

GRADUATES OF 1900.—Enclosed in the diploma of every one of you will be found a copy of the Code of Ethics to guide you in the discharge of your always responsible and often perplexing duties. It has long been accepted by the ablest and the noblest of the men who have adorned the medical profession, and it deserves your acceptance. If you would be honored by those who are themselves most honored you must conform to its requirements. Often criticized, this code can never become obsolete until the morality of Christ has ceased to find an echo in the heart and in the conscience of mankind.

On the roll-call of this day should have been the names of Monette of Mississippi, Nash of Texas, and Patton of Louisiana. Never forget why these our valued students and your loved comrades are this day absent, and resolve that the lives that gave such assurances of usefulness to mankind shall not have been sacrificed in vain; that humanity shall gain through you the sole compensation for their untimely end now possible. Advocate and execute incessantly all possible measures to prevent disease until your efforts shall have rescued from death hundreds of lives for the life of every one of your absent friends. Not for you the soldier's stimulants to battle, not for you the roll of the drum, the blare of the trumpet, the rattle of arms, the tramp of comrades' feet, the exhilarating voice of a trusted commander, and the fierce cheers of conflict and of victory; but it is the ardent hope of your faculty that sense of duty and the memory of your dead comrades will arouse in you and keep ever alive a fierce rage of battle against the foul disease that struck them down in the joy and pride of their young and hopeful manhood.

The profound thanks of the Faculty are justly due to you for your courage, loyalty and devotion during our time of anxiety and trial and for your irreproachable conduct throughout the years of your apprenticeship as students. May you live long and prosper and gain your prosperity by contributing to the health and happiness of others.

MEDICAL JOURNALISM.*

BY CHAS. CHASSAIGNAC, M. D., PROFESSOR ON GENITO-URINARY AND RECTAL DISEASES AND PRESIDENT OF THE NEW ORLEANS POLYCLINIC, ETC., NEW ORLEANS.

When, at periodic intervals, the medical journal reaches the reader's hand, few realize how much it means to the peruser himself or how much labor, thought, and discrimination it represents on the part of the editor and manager.

Outside of the comparatively few who can travel to large centers in order to take part in congresses and conventions, and of those, fewer yet in number, who, living in the atmosphere of large hospitals and laboratories, are in close touch with men who are making medical history, all physicians acquire any knowledge of the progressive strides being made in medicine and surgery chiefly through the medical press.

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*Annual Address as President of the Charity Hospital Alumni Association, at the meeting in New Orleans, April 18, 1900

The text-book and the monograph fill their proper place; their value must not be depreciated, and the student must have access to them in order to grasp a subject in its entirety, but they take a long time to publish and distribute. It is the medical journal which carries the idea of a thinker or the invention of a genius hot from the brain of the originator to the receptive faculties of the reader. It brings it fresh, not only in the sense of without loss of time, but it does so at what is perhaps the opportune moment, the timely period at which the medical mind is ripe for the discussion of a given subject or is in need of information in a special direction. Unlike the book, however, it is not the thought or knowledge of a single mind on a certain question that the medical periodic furnishes; it gathers simultaneous opinions and observations from different individuals and various sources, thereby enabling the subscriber to reach a conclusion or formulate a course of action after hearing all sides of a mooted point.

Only through medical journals can the statistician gather the data necessary for his tabulations. The number of more or less costly volumes which would otherwise be required by him would already make his task an arduous one as far as it could go; but the majority of distinct cases, or observations, or experiments which, in the aggregate, furnish the facts necessary either to confirm a theory or destroy an illusion, would never see the light, as it were, or become general property, if the pages of such medical publications were not open to the average writer or reporter.

How could we ever determine the true value, for instance, of a new operation? Its conception might be brilliant, it might be based on apparently sound principles theoretically, yet it would be impossible to judge of its real merits unless and until we could gather knowledge of ultimate results from a large number of operators; only through the columns of the medical journal can a sufficient number of such reports, from different parts of the world, be accumulated in due time.

Again, how could the accurate indications for a given procedure ever be thoroughly elucidated unless the evidence could be multiplied and be derived from various sections, from different types of surgeons, and under all sorts of circumstances?

The editorial department adds another item to the value of the medical periodic. If, as an humble member of the craft, I may be pardoned for so saying, medical editors are, as a rule, progressive and unselfish, hence are on the alert to stimulate advance on the part of the profession, and are ready to champion any action tending toward the betterment of the members of the calling. Efforts which would be futile on the part of individuals can be combined and directed through the agency of editorial writings and made to achieve their purpose.

The intelligent reader is also greatly assisted in the selection of the books that would most interest him, and that he needs most, by the perusal of such a department of book-reviews as is included in an honest journal. He gets information as to the latest medical literature, thereby not only enabling him to avoid the works which would prove a disappointment and a wasteful expense, but in addition whetting his appetite for the books which are shown to him to be of interest and value. In these days of competing publishers and of prolific writers who do not hesitate to repeat themselves and borrow from others, the book reviews contained in an intelligently conducted weekly or monthly are alone worth the price of subscription.

Even the advertising department is not without advantages to the medical reader, if the management of the journal be honest and careful. Novelties and improvements in preparations and in instruments are brought to the subscriber's notice more promptly and more forcibly than by any other method. At the same time the physician is aided in selecting the best quality of a given product, and the best establishments for purchasing certain articles, as he is aware that first-class and dignified journals are apt to accept advertisements only from trustworthy manufacturers and just dealers.

If the weighty significance of the medical journal to the reader is understood, let us turn to what the publication means in work and mental effort on the part of the editor.

First, the importance of publishing all he should publish is equalled only by the necessity of not putting in what should be excluded.

He must see that the latest discoveries, the newest inventions and the freshest experiments receive adequate attention in some department or other; and that means extensive reading and voluminous correspondence, not to mention the judicious use of the scissors. Writers have to be stimulated, coaxed, or entreated as circumstances may demand. A still hunt must be made for those who may have had cases of special interest, with the expectation of additional labor in extorting from them observations and reports of the same. The medical news of the day must be ferreted out and the burning topics of the hour must be studied in order not only that the diganosis of a situation may be made, but that attention may be directed to what the prognosis would be in the event of inadequate interference, and also that the proper treatment may be mapped out and urged upon those who should carry it out.

Judgment must be used in the distribution of books to the reviewers in order that the former may receive attention at the hands of those best prepared to do justice to their respective subjects; otherwise, the book notices, whose possible value has already been pointed out, would be comparatively of no benefit to the reader and the space devoted to them would in reality be wasted.

While the great importance of giving publicity to everything deserving of it is obvious, the reader, whom only the proper selections and siftings reach, has no idea of the care necessary to prevent the slipping in of improper papers or reports of cases written for pay by authors who merely wish to puff some special preparation. It takes great vigilance to detect in those sometimes well and ingenuously written, but dishonest and consequently dangerous articles, the hidden scheme, the sly reference to the product it is intended to boost. Such an instance came to the writer's notice recently. A quite well-written article came in, having been mailed at a town in an adjoining State; with it was the request for the return of the article to such and such an address in that town in case of its non-acceptance, and for a goodly number of reprints in the event of its publication. When the paper was carefully scanned, an innocent looking reference to a proprietary article was detected, and was easily determined to be its *raison d'être*. The manuscript was returned forthwith to the supposed writer, and in due time came back again with the endorsement by the postal service to the effect that no such person could be found at the address given, and he was never heard of again. The inference is obvious.

The conscientious editor or manager must exercise great vigilance in the supervision of the advertising columns. Proprietors of non-ethic preparations and promotors of dishonest schemes are willing to pay handsomely for the privilege of being represented in the pages of a respectable journal, and their schemes are numerous and shrewd. The only safeguard is in having a high standard as well as rigid rules and in upholding the former and enforcing the latter.

And now, when finally all the subject matter has been selected and edited; when it has been assorted, measured, and handed to the printer, it might be imagined that the work is nearly done. The one who so imagines can scarcely ever have had any dealings with the type-setter and the proof-reader. He is unaware of the malicious joy the former takes in distorting the meaning of the finest sentences and of the great glee with which the latter abets him by letting the errors quietly slip by. He has never burned the midnight oil, by the way causing his eyes also to burn, scanning "galley" and "form-proof" and "revise" in the attempt, sometimes vain, to defeat the diabolic combination just referred to.

This fight more or less completely won, there yet remains the prodding of the publishers; the discounting of blue Mondays and of holidays, which the printers celebrate so frequently by looking upon the beer when it is amber-colored and frothy; all this to the effect that the number in hand may be distributed strictly on time to you—readers—and that you may derive some satisfaction from it on the day upon which it is expected to make its appearance.

You have no doubt noticed that the terms honest journal and conscientious management have been used repeatedly. The object is to make the distinction between the medical publications of first-class standing and those, too numerous to-day, of no standing at all; between the ones who have a *bona fide* paid subscription and those who depend for circulation upon a ridiculously low rate and the distribution of free samples; between the ones who select their advertisers and such as accept any "ad" that "has money in it;" between the kind that seeks faithfully to aid and enlighten its subscribers and the others whose sole aim is to inveigle its readers into trying some nostrums it is paid to promote.

The medical profession can best elevate its standard and enhance its interests by casting out the fake journals, the mushroom advertising sheets that spring up to-day and are gone to-morrow, the medical "yellow journals," and by giving deserving aid and patronage to the dignified organ of a dignified profession.

Clinical Reports.

REPORT OF A CASE OF GUNSHOT WOUND OF LEFT LUMBAR REGION, PENETRATING ABDOMEN—THREE WOUNDS OF COLON AND ONE OF STOMACH. CELIOTOMY. ENTERORRHAPHY. RECOVERY.*

By E. D. FENNER, M. D., First Assistant Surgeon, Charity Hospital, Lecturer and Clinical Instructor on Diseases of Children, Medical Department of Tulane University, New Orleans.

John Lewis, colored, male, aged 16 years, was brought into the hospital about 3:30 p. m., on February 27, 1900, with a gunshot wound of left lumbar region; there was no wound of exit. The boy had eaten a hearty meal and drank a good deal of claret, and there was much vomiting and some shock. Nothing characteristic about the vomited matter. Tenderness and pain were referred to the region of the wound.

As soon as the abdomen could be prepared operation was done, about three hours after injury.

Operation.—Under chloroform anesthesia, incision in median line, about eight inches long. A considerable quantity of blood was found in the cavity, with a few particles of matter from the bowels. The bullet had perforated the descending colon twice, very near the splenic flexure, and inflicted a third wound which cut through the serous and muscular coats, but did not penetrate the mucous membrane. The bowel was comparatively empty and there had not been much escape of fecal matter. One of the wounds involved the mesenteric attachment and some trouble was had in properly securing it. The location of the visceral injuries made them somewhat inaccessible and necessitated a large abdominal incision.

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*Read at the Annual meeting of the Louisiana State Medical Society, New Orleans, May 19, 20, 21, 1900.

The stomach was half-full in spite of the free vomiting, and presented at the cardiac end a wound of the serous and muscular coats, but with the mucous membrane intact. This, like the wounds of the intestine, was secured by Lembert sutures of fine silk.

The bullet had evidently ranged upward and forward, but we were unable to discover where it had gone after striking the stomach.

The abdominal cavity was well flushed with hot normal salt solution, a good deal of which was left in the cavity, and the abdominal incision was closed with through and through sutures of silk-worm gut. In addition the skin was approximated by a number of superficial sutures of the same material. The bullet wound in the back was sealed with cotton and collodion and a copious aseptic dressing applied to the abdomen, fixed with strips of rubber plaster and a Scultetus bandage.

The operation lasted about an hour and a half from beginning of anesthesia to completion of the dressing.

Clinical Notes.—First day. No vomiting followed the operation. No pain was complained of on recovery from anesthesia. The patient was very tractable, lying perfectly quiet and sleeping most of the time. His nervous system did not appear to be highly organized and sensitive, which no doubt was a favorable condition.

Water in tablespoonful doses and cracked ice were allowed during the night. Hypodermic stimulation of tr. digitalis, minims iii, strychnin sulphate, gr. $\frac{1}{90}$ every four hours. Ice bag to abdomen.

Second and third days. Moderate tympanites developed, causing patient to complain that bandage was too tight; this subsided slowly during next two or three days. Vomited once during night of third day.

Fourth day. Up to this time water in doses of ʒss and cracked ice was all that was allowed. Milk punch, Ducro's Elixir and beef tea in ʒss quantities, alternating every two hours, were now allowed. Vomited once.

Fifth day. Strained orange juice and chicken soup added to diet.

Sixth day. No movement of bowels up to this time. ʒiss sodium phosphate in solution, every two hours for five doses, producing two large movements. No pain resulted. Abdominal dressing changed.

Seventh day. ʒiss sodium phosphate three times a day. One movement of bowels.

Eighth day. Hypodermic stimulation discontinued. Wound dressed; several stitch abscesses found. Bowels moved. A considerable quantity of red arterial blood passed. No pain or bad symptoms resulted. Morphin sulphate, gr. ⅛, fl. extr. ergot, ʒss, by needle. Ice bag reapplied to abdomen. Food stopped.

Ninth and tenth days. Only water in small quantities allowed. Nothing special to note.

Eleventh day. Another movement of bowels with hemorrhage. Hypodermic of morphin, gr. $\frac{1}{8}$, ergot, ʒss; ice bag to abdomen.

Twelfth day. Wound dressed, stitches removed, small abscesses having formed about them.

Thirteenth day. Nourishment resumed. From this time nothing occurred requiring special comment. The bowels moved every second or third day. The diet was gradully increased in quantity and variety. The stitch abscesses were dressed frequently and on twentieth day the operation wound was entirely well.

Twenty-sixth day. Patient up out of bed.

Thirty-second day. Discharged cured.

SPECIAL FEATURES.—No food till fourth day. No movement of bowels till sixth day; intestinal hemorrhage on eighth and eleventh days.

For the excellent clinical record and for the careful attention to the patient, which no doubt influenced the favorable termination, I am indebted to Mr. Allen, the interne of the service.

A CASE OF DERMATITIS HERPETIFORMIS IN A CHILD THREE YEARS OF AGE CURED BY CIRCUMCISION.*

BY J. N. ROUSSEL, M. D., NEW ORLEANS.

This case is interesting, and I report it for the following reasons, to-wit:

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*Read before the Orleans Parish Medical Society, at the meeting of February 10, 1900.

First—The disease being a rare one, I believe that the interests of dermatology are best subserved by reporting all such cases, and more especially the cases in which the exciting cause is probably known.

Second—The patient being only three years of age, and having had it for two years, renders it interesting in this particular instance, because a goodly number of very eminent dermatologists, both in this country and abroad, are disposed to believe, and so express themselves, that the affection is never or scarcely ever found in those so young.

Third—After circumcision for a very pronounced phimosis, the affection having entirely disappeared, with no other form of treatment, is more than probable evidence of its reflex origin, which, in this particular case, is especially interesting, because it is probably the first and only case on record, in which phimosis has been recognized as the exciting cause.

The subject of this report, a male child of three years of age, was brought to my clinic at the Touro Infirmary during the early part of October by its mother, who implored me to do something for her child.

She said, in giving the history of the condition, that when the child was about two weeks old, there appeared upon its lower limbs, abdomen and buttocks, quite a number of pin-head sized blisters, which remained a few days and disappeared without treatment.

When the child was a year old, they reappeared and until now he has never been entirely free from them, not even for a day, in spite almost continuous medication.

Up to this time, he has, according to the statement of his mother, enjoyed good health in every other way. He has always looked well, ate well and was, in fact, well, with the exception of the eruption.

But it was apparent, that while the child may have been well for these two years, the disease was beginning to make serious inroads into his health, as was evidenced by slight elevations of temperature, a beginning loss of appetite, and a sallowness begotten of some serious pathologic disturbance.

The family history was good, at least, as far as I could discover, and the general condition of the patient fairly good, with the exception of the sallowness above referred to.

The eruption was very generously distributed over the lower limbs, genital organs and buttocks, with a goodly number of lesions on the back and forearms, and a few on the face and neck, but none on the scalp.

The lesions consisted, for the most part, of circinate and papular erythematae, vesicles and bullae situated upon an erythematous base, itching intensely and having a tendency to group. The vesicles and bullae predominated.

They first made their appearance as a raised erythematous patch, upon which appeared the vesicles, very small at first, but rapidly increasing in size, and forming a picture, in isolated patches, not unlike that of a herpes zoster in its incipiency. But in the course of a few hours, or days, in some instances, the vesicles would run together, and form bullae, which were irregular in outline, with no tendency to rupture spontaneously.

They were usually ruptured, however, in a short time by the nails of the little patient, who sought eagerly for relief from the intense itching by scratching, with the result that quite a number of the lesions had been infected, and appeared very angry and inflamed.

These lesions, of course, were a few days in healing, and usually, as did the balance also, left spots of peculiar brownish hue.

This condition continued, with recurring exacerbations, for two years, as stated above, and accompanied by such intense itching as to have made life a veritable burden for the little patient.

With the view of determining whether there was an increase of the eosinophilous leucocytes, the fluid from the bullae was examined microscopically, with the result that where we usually find in ordinary blisters of mechanic origin, as it were, about 8 per cent. of eosinophiles, there were in this fluid at least 30 per cent., which speaks in favor of the diagnosis.

The urine was normal.

In conclusion, I will say that there is so much to be said *pro* and *con* regarding the diagnosis of bullous eruptions in general, that I have deemed it wise not to indulge in any remarks upon the subject, believing that they will be fully brought out in the discussion that may follow.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

THE NEW ORLEANS CITY BOARD OF HEALTH.

In the body politic conditions are created by the necessities of a civilized community which need remedy as much as in the individual sick with disease.

In each department of governmental order, system gradually evolves with the completeness of the component parts of that department. Public safety, in the provinces of police jurisdiction, judiciary and sanitary protection, is increased or lessened by the efficiency or insufficiency of the power and application of these offices.

The health of a community, town, city or State, depends directly upon the several conditions of sanitary system which may prevail. In every modern community, no matter how small or how large, there is a prompt tendency to improve the hygienic conditions. If governmental provision does not exist, community interest finds some way of meeting the needs.

So each State has from the necessity of the thing recognized the importance of health supervision, and appointive officers have been created to fulfill the conditions. In some States these officers are more far-reaching than in others; in some States the health authorities are restricted to a few exigential duties solely, while in others the whole field of the public health is embraced in every branch of this question, from food impurity, sociologic problems, drug adulteration, to the administration of the qualifications to the practice of medicine.

Louisiana has responded to the demand of progress and today has a State Board with limited power of activity*. For many years New Orleans represented the State of Louisiana to the outside world, the other communities being so small as to have no municipal voice in comparison with the metropolis. The last decade, however, has seen several important centers of population develop in Louisiana, where commercial interests have grown apace with educational and community advantages.

While in the past it may have been quite right and proper for the State Board of Health to have exercised its office in and near New Orleans, we question the wisdom of reverting to this condition of things, when we have already made a step forward by organizing local boards of health.

It is no more logical to dispense with a separate health board in Shreveport, Lafayette or Slidell, and to relegate the work of such board to the State Board, than it is to suggest that even in part the New Orleans City Board of Health should be so disposed of.

The creation of local boards of health in the several cities and parishes of Louisiana has already demonstrated the fulfilment of the highest means of improving community health, namely, the education of the people to the need of such kind and sort of care. In time these local boards will grow in usefulness and in purpose.

The State Board of Health likewise will broaden its powers as time goes on. Just because the question of quarantine sits as a grim specter over the Board of Health office is no reason why this should always be so.

The City Board of Health in New Orleans has demonstrated its usefulness in more ways than one. Just because the conditions of its financial support have prevented its actual operation in some lines is not sufficient argument for its demise. No physician would order a coffin because he did not happen to have the proper remedy in his pocket. *He would go and get it!*

New Orleans needs a City Board of Health. Its sanitary conditions need supervision by qualified men interested in New Orleans, and interested chiefly and always in New Orleans. The City Board has successfully combatted small-pox without the assistance of the State Board, and in spite of the fact that the spread of the disease was due to importation of cases from outside New Orleans, for which the City Board could not be responsible. House disinfection, domestic hygiene, and a host of other incidental details have been and are being done by the City Board, notwithstanding the cavil and hypercritic attacks at the hands of those either misinformed, misguided or ulteriorly interested.

The City Board of Health should be untramelled by financial embarrassment; then the grounds for fault-finding and for attack would fall.

THE CODE OF ETHICS OF THE AMERICAN MEDICAL ASSOCIATION. INCIDENTALLY.

"*It is rumored, apparently upon good authority, that the German chemical houses will attempt to control the Section of Materia Medica of the American Medical Association at its next meeting.*" So begins one of several communications received by the Journal from drug concerns in the United States, and, in substance, there is also an urgent request that the Journal notice the communication.

The suggestion is shocking. We can not believe that the rumor is more than smoke from a very small fire, for if the representative body of the medical profession in this country could in any of its component parts so prostitute the high privilege it enjoys, and should drag in the mire of notorious disrepute the highest purpose yet conceded to mankind, we feel that the time has nigh come when even the physician is venal to the degree of a small, very small price. We can not believe it!

But the accusation stands, and the judiciary committee of the American Medical Association owes it to the vitality of that body that an investigation shall be made. The hue and cry may be only the bark of the dog on the other side of the fence, but the gentility of the membership of the American Medical Association must not be made the shuttlecock of commercialism.

Incidentally, there is a code of ethics, writ in large type, which governs each member, and not less those men who are now impugned. Let them so nail the lie, or the truth, that there can be no further question of the honesty of the American physician!

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of DR. F. W. PARHAM, assisted by DR. F. LARUE, New Orleans.

THE AMERICAN SURGICAL ASSOCIATION.—The meeting of the American Surgical Association, just held in Washington, was one of the most successful in its history. The subject of discussion was the Surgery of the Stomach. The reports of the proceedings are not all in at this writing, but we hope in our next issue to give a brief digest embodying the salient features and practical results of the free interchange of ideas of the prominent debaters at this meeting, which will, we feel sure, prove an epoch-making meeting so far as surgery of the stomach is concerned. The success of this meeting will show the wisdom in all gatherings of this kind of having a general subject for discussion, so that the collective energy of the whole society may be concentrated upon the elucidation of some one topic and not, as so often happens, be dissipated in the discussion, desultory in character, of numerous ill-digested papers.

ON THE CLOSURE OF WOUNDS OF THE WALLS OF CAVITIES BY MEANS OF THE SILVER WIRE NET.—The employment of foreign bodies in the closure of abdominal wounds dates back now some years. Impelled by his unsatisfying results in certain cases of hernia, Trendelenburg was led to try the implantation of a plate made from a freshly resected humeral head into the hernial opening. This was done with success in 1890 in the case of a scrotal hernia. Later he modified the procedure by utilizing a periosteo-bone flap taken from the pelvis of the patient himself. The substitution of a material, inorganic in character, and calculated to withstand absorption, followed. The use of silver wire for this purpose is familiar to all. Whatever may be urged against its routine use for the closure of ordinary hernias, that may be easily and safely closed with absorbable material, it may be freely admitted that there are cases where the absorption-resisting material may, with advantage, be resorted to.

Whether, then, we employ silver wire in all cases, as do some, or restrict our use of it to these special cases, the fact remains that our surgical necessities still urge us to improve our silver wire technic in order that we may get the best attainable results.

Prof. Witzel, of Bonn, published in *Centralblatt für Chir.*, No. 10, 1900, an article on the use of the silver wire mesh in the closure of belly and hernial openings. It at first occurred to him to use the previously prepared wire mesh, but he found it better in general to make the mesh during the operation by the manner of putting in the wires. He returns to the subject in No. 17 of the *Centralblatt*, emphasizing the advisability of thus preparing the network by the method of suturing, except in the case of flat bones, where it would be desirable to prepare the material beforehand.

In the same number of *Centralblatt*, Robert Goepel of Leipsig also takes up the subject, arguing for the use of the wire network prepared in advance. He finds the method very satisfactory in umbilical and inguinal hernia. His first use of the wire net was in a case of umbilical hernia in March, 1897. Since this time he has carried out the method without essential modification in 18 cases (11 cases of umbilical and neighboring ventral hernias and 7 inguinal). Among these was one patient with a hernia of the size of a child's head, with strong forward bulging of the abdominal contents. Of these 18 operations were only two miscarriages, in cases where on account of hematoma formation the wire had to be removed. All others were successful. The wire net healed in easily in all other cases, and caused no inconvenience even in laboring men.

He concludes: "In addition to the use of the wire mesh in the closure of abdominal openings it has still wider application in all cases where it is desirable to support a tissue mechanically, the aseptic conditions for the healing in of a foreign body being given, as in furnishing support to the roof and point of the nose, for the closure of skull defects, for the artificial replacement of the trachea, for the closure of great defects of the abdominal wall the result of the removal of tumors of the wall, or as Witze has suggested, for the mechanical substitution of bone losses.

In all this there is much promise.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller,
New Orleans, La.

Incarcerated Retro-Displaced Gravid Uterus.—A discussion of this subject before the Obstetrical Society of London, April 4, developed the fact that it is often very difficult to diagnosticate this condition. Dr. Menro Kerr (Glasgow) read a paper in which he pointed out that three varieties of backward displacement of the gravid uterus might be met with, viz.: retroflexion, retroversion and partial or incomplete retroversion.

Dr. Alban Doran had seen a case in which the cervix was to the right and the elastic fundus to the left, exactly simulating extra uterine pregnancy, but a few days' delay cleared up the diagnosis.

He referred to Unterberger's case, where a gravid uterus, displaced by a fall in the first month, caused distension of the bladder which forced open the urachus, and allowed the urine to flow from the umbilicus. Rupture of an ovarian cyst through the umbilicus was diagnosed, but Unterberger emptied the suspected cyst by passing a catheter through the umbilical opening and another through the urethra. The uterus retroverted and retroflexed, sacculated and partially incarcerated, righted itself and delivery occurred at the fifth month.

Dr. Arthur Giles reported to the Society two cases in which extra uterine gestation had been mistaken for retroversion of the gravid uterus. Also, one where a retroverted uterus simulated ectopic gestation. In the latter instance the mass in Douglas' pouch was reduced under anesthesia and was found to be distinctly bilobed, the left lobe feeling like a gravid tube. In a fortnight's time the uterus had resumed its normal shape. Abortion ensued two months later.

It was the general opinion that a general anesthetic was a requisite to a satisfactory examination.

The majority of the speakers discountenanced abdominal section for the reduction of incarcerated gravid uteri.

Dr. Herbert Spencer had not yet seen a case in which it had not been possible to replace the organ. Sometimes the replacement had not been effected at the first attempt, and sometimes the organ had righted itself after ineffectual attempts at replacements had been made. In his opinion the only cases requiring abdominal section were those in which the organ was fixed by strong adhesions.

The point of rest in bed was especially dwelt upon.

Retention of urine seems to be a very common complication, judging from the number of cases mentioned in the discussion. —*British Med. Jour.*, April 14, 1900.

TREATMENT OF FIBROMYOMA OF THE UTERUS.—The *British Medical Journal* (April 7) contains the report of a discussion of this subject by the members of the North of England Obstetrical and Gynecological Society. The special points selected for discussion were: Choice of route; 2, myomectomy; 3, total versus supravaginal hysterectomy; 4, the treatment of the appendages; 5, technic; 6, drainage; 7, after results of operations.

Dr. Grimsdale said that the indications for operative interference might be divided into relative and absolute. The relative indications comprised are the various well known symptoms, including the mere presence of a tumor. The absolute indications covered all possible accidents which might happen calling for immediate operation. Of these he had met with tumors obstructing delivery, torsion of the pedicle, of a subperitoneal tumor causing acute peritonitis, suppurating fibroid tumors which might result sometimes from thrombosis of the vessels and ascites from chronic peritonitis, especially calcifying tumors. The relative indications might be divided into vaginal and abdominal. Amongst these there might be: 1. Rapid growth of the tumor due sometimes to cystic degeneration. 2. Pain due to pressure and often to accompanying disease of the appendix. 3. Size and weight incapacitating a patient. 4. Pressure symptoms, especially on bladder, rectum or ureters. 5. Severe hemorrhage. 6. Fetid discharge, which usually indicates a tumor protruding into the vagina. With respect to the choice of route, generally speaking vaginal symptoms required the vaginal route, while abdominal symptoms indicated the selection of the abdominal route. The combined method was often a confession of failure to complete the operation undertaken in the first place. The mortality after either abdominal or vaginal operation was mainly due to sepsis, and experience had seemed to show that it was easier to avoid infection from without by operating per vaginam, but now results of abdominal opera- were so good that it might be considered as safe as the vaginal route. The avoidance of hernia and absence of a scar in vagina operations were not factors of great importance.

Factors against the vaginal route were difficulty of diagnosis; in some cases, tedious operation; myomectomy could rarely be carried out efficiently.

Grimsdale preferred the method of Baer for abdominal hysterectomy and did not use any drain. Myomectomy, which could be performed either by the mucosa of the uterus or through the peritoneum, had enormous possibilities of usefulness.

The general trend of the discussion was towards myomectomy whenever possible.

Dr. Hellier, president of the society, strongly advocated vaginal drainage after hysterectomy, since there was often a considerable amount of effusion into the pelvis.

THE CLINICAL VALUE OF THE NEWER METHODS IN TREATMENT OF PUERPERAL SEPSIS.—Dr. John Polak concludes an extensive article on the above subject by the following:

1. That puerperal sepsis usually begins in one of two forms of endometritis, *i. e.*, putrid or septic. Except when the infection has been direct through the inoculation of lacerations and abrasions by the streptococcus or by the tetanus or diphtheria bacillus.

2. That while the curette is indispensable to the successful management of putrid endometritis, it is harmful in an empty uterus, such as is commonly found in the septic form.

3. That all forms of septic infection are benefited by general stimulation and supportive treatment.

4. That of antitoxics used, ungt. Crédé has proven its superiority over the anti-streptococcic serum.

5. That blood washing and the artificial production of a hyperleukocytosis are valuable adjuncts to the routine treatment.

6. That hysterectomy post partum should be limited to those cases in which sepsis is localized, as a metritis, pyosalpinx, or tubo-ovarian abscess, after the acute symptoms have somewhat subsided, and that most parametric pus collections can be more safely handled by vaginal section.—*The Postgraduate.*

Department of General Medicine.

In charge of DR. E. M. DUPAQUIER, New Orleans.

CONTRA-INDICATIONS TO THE USE OF DIGITALIS.—It is good to know the contra-indications as well as the indications in the use of digitalis, for where the latter is unserviceable it is certainly harmful, not only by reason of the accidents it may provoke, if continued, but also and chiefly because on the one hand it becomes less efficient when repeated, while on the other it is not tolerated a long while. Now, then, the indications being frequency, irregularity, weakness of the pulse-beat and dropsy of the connective issue, or of the serous membranes, it can be said, in a general way, that any other condition forms a contra-indication. But we meet with circumstances which demand particular attention.

In the first place, there are certain misleading forms of permanently slow pulse, in which the pulse is only apparently slow owing to the fact that the heart, being in a weakened state, the cardiac beats are not all felt at the radial. This kind of slow pulse, while not indicating digitalis apparently, does actually indicate the use of it. Next, a frequent, irregular and weak pulse, although in a general way indicating digitalis, may be due to conditions actually contra-indicating it, as for instance severe myocarditis, profound adynamia, senile cachexia, cardiac dilatation liable to cause at any time severe cardiac asthenia, finally fatty degeneration. In all such conditions where the myocardium is altered, not only is digitalis poorly if at all efficient, but it may cause accidents and dangerous ones at that. Consequently, whenever any of these conditions is suspected, it is indicated to either abstain from or be very cautious in using digitalis.

Again, a case of incompetent aorta forbids in general the employment of digitalis; yet, when the cardiac beats are increasing in number, digitalis is serviceable. Dyspepsia is a contra-indication to digitalis, for patients do not bear it well or retain it at all, and most unfortunately, the hypodermatic administration is too painful to be thought of as a permanent substitute.

Any form of cachexia also prohibits the use of digitalis; finally, when the drug has already been used, it is safer not to use it again, for the prior administration not only hinders its efficacy, but it accumulates its noxious effects.

With reference to the dangerous accidents which occur during digitalis medication, not every one is familiar with them, or at least, not every one interprets them correctly.

Very often there happens at night some delirium which passes unnoticed. Next, follow pallor, lowering of normal heat, agitation, angor (a feeling of constriction at the epigastrium, with a great difficulty in breathing), and contraction of pupils. When a case goes that far, a fatal syncope may come suddenly; some, however, pass away gradually.

Death from digitalis happens, chiefly in cases of Bright's disease, arthritism, severe anemia, aortic incompetency and delirium tremens.

The use of digitalis is followed at times by typical psychoses, melancholy and agitation without marked disturbances of the circulation.

In cases of diminished diuresis the dose is increased, intoxication takes place, and the patient dies suddenly.

Finally, digitalis may indirectly cause apoplexy of the lungs, when there exists a tricuspid incompetency, for the pressure, usually lowered in the pulmonary artery, is suddenly raised and some of the vessels may burst under the strain.

For that reason, the dose of digitalis in cases of tricuspid incompetency must be reached gradually, the increase being say of one-fifth of a milligram at a time.—LUCAS-CHAMPIONNIERE in *Journal de Med. et de Chir. Pratiques*, April 10, 1900.

BRONCHO-PNEUMONIA, THE ONLY CAUSE OF CACHEXIA IN CHILDREN SUFFERING FROM GASTRO-ENTERITIS.—" Here is a little girl, four months old, emaciated, with a large flabby abdomen. She is bottle-fed with cow's milk from a neighboring dairy. The milk is diluted with one tablespoonful of water to the pint, in other words, it is almost undiluted. She is fed every two hours during the day and twice during the night, in other words, much too often, since an interval of three hours between feedings is necessary when undiluted cow's milk is used. Such a diet brought about vomiting, green stools, erythema of the buttocks, flabby belly, elongation of the bowels (by paralysis of their muscular coat), and the costal 'string of beads.'

"You see her wretched appearance. She is atrophied, her weight is inferior to that of a normal child of the same age. But she is not only atrophied, she is becoming cachectic. Note that she has no aphthous stomatitis.

"I auscultate and find at the left base fine mucous râles; *this is a regrettable complication.*

"Broncho-pneumonia gravely imperils the days of this child, as it does with all sucklings fed in such a lamentable manner. Broncho-pneumonia is the only cause of their cachexia.

"A child whose diet is incorrect ceases to gain in weight; but it is not cachectic. To become so, its tissues must be dehydrated, its fontanelles sunk, its skin flabby, and all these changes are not brought about under the influence of bad alimentation alone.

"When we see a child who not only lacks the weight of its age, but presents a flabby skin, depressed fontanelles and dehydrated tissues, *we be may sure that it has broncho-pneumonia.*

"Often, in this hospital, we have admitted children who were neither athrepsic (Parrot's term for a chronic state of malnutrition in infants) or cachectic, but, presenting diarrhea, vomiting and underweight. After a few days of a good diet, the diarrhea and vomiting had ceased; yet, as time passed, these children did not gain in flesh, they became cachectic. The digestive disorders which had caused emaciation had disappeared, and then the reason why this increasing and persistent bad condition existed was sought for. At first, I thought of a generalized infection by microbes and toxins at the time of the gastro-intestinal disturbance, but this was all a theory. To-day, I attribute the cachexia in such cases to broncho-pneumonia, basing my view upon the following facts:

"I have performed a very large number of autopsies of cachectic sucklings and kept a record of them during seven or eight years. I found that it was impossible to fix any relation, either between the lesions of the gastro-intestinal tract and the cachexia observed during life, or between those lesions and the vomiting. On the other hand, I always met lesions of broncho-pneumonia, condensation of both bases into a tissue analogous to that of the spleen, and pus filling the smaller bronchial tubes. During life this broncho-pneumonia had never been even suspected. The temperature, high one day, low the next, even lower than the normal, was not suggestive; moreover there were absence of dyspnea and hardly any cough. Enlightened by these anatomo-pathologic facts, I subsequently found that in such cases broncho-pneumonia revealed itself only by a weakened respiration at the base, with fine mucous râles and no constitutional symptoms whatever.

"To-day, in a weakened child, I firmly base my diagnosis of broncho-pneumonia on these insignificant signs, and I am not mistaken. I am still proceeding with my researches on this line.

"Reverting to the child presented to you, I shall treat her case of gastro-enteritis with an appropriate diet and her case of broncho-pneumonia with warm baths and injection (rectal and subcutaneous) of artificial serum."—MARFAN, *Clinique des Maladies Infantiles.—Journal de Médecine Interne*, April 1, 1900.

Department of Therapeutics.

In charge of DR. J. A. STORCK, New Orleans.

HOT-AIR THERAPEUTICS.—Notwithstanding its conservatism in some directions, the medical profession continues to hold a front rank in progressive science. That is to say, it is ever in search of truth, and ready, sooner or later, to accept any discovery, however startling and revolutionary its nature, provided only that the new thing is able to establish and maintain a claim to recognition. Every year its members are faced with a host of fresh remedies, heralded by a flourish of literary trumpets, but fated, for the most part, to fade away into obscurity after a brief sojourn of a year or two in the land of their desire. A few, on the other hand, come to stay. Of the lasting order it may safely be said, after nine years' experience, is the superheated air treatment introduced by Mr. Tallerman.

Heat, as every one knows, has been recognized as a valuable therapeutic agent since the dawn of medicine, and possibly long before that period by prehistoric man. There is no need to cite the familiar poultice of the linseed-meal type, or in its later scientific form as the wet compress with an external waterproof covering. The Turkish bath is another way of applying heat to the body generally, and the value of the principle involved has been recognized for many centuries, more especially in Eastern countries and in Southern Europe, in the treatment of disease. Hot springs and hot baths have also been recommended by physicians from the earliest times of recorded history.

The special value of hot-air and vapor baths and of warm springs has naturally lain chiefly in the treatment of gouty and rheumatic conditions, or in that large class of hybrid cases which partake of the characteristics of both maladies. In spite of a full and prolonged experience of spas and of specialized baths, however, their most ardent apostle could not claim more than a modified success. Some early cases of gout and subacute rheumatism might be benefited, perhaps materially so, but how many could be said to be permanently cured by a course of Turkish baths or by a prolonged stay at an English or German spa?

As for rheumatic gout, or osteo-arthritis, as it is now called, the disease has proved rebellious to any plan of treatment, whether by drugs or by external measures yet known to scientific medicine. Now and then, in rare instances, the osteoarthritic process appeared to be arrested, but whether as the result or in spite of treatment, remained an open question. So, too, with the chronic gouty and rheumatic affections of joints; there was no certainty, not even a reasonably sound probability, that the sufferer might obtain relief from a systematic course of external and internal treatment.

Now all that is changed, and it is not too much to claim that a new era has been introduced into the treatment of diseases of the gouty, rheumatic, and osteo-arthritic type. The key to the Tallerman method is the drying of the air, whereby the patient is able to withstand a temperature of 300 deg. F. without discomfort. As a comparative temperature, we recall the fact that the hottest room of a Turkish bath rarely reaches 230 deg. F.

The administration of the bath is simple. The patient, after being undressed and wrapped in blankets, has his arm or leg or other part of the body placed inside a specially constructed cylinder, which is heated to the required point by oil, gas, or electricity. A trained nurse is in constant attendance, and the exposure is kept up for half or three-quarters of an hour. The patient breaks into a profuse perspiration and the body temperature runs up a couple of degrees. That is all.

The results, pure and simple, of this process are marvellous. Although the application is local, the effects are general, so that treatment of a right hand, say, will cure a rheumatic attack in a left knee. In nearly all cases pain is instantly relieved, often for long periods or permanently. The movement of joints, unless they are fixed by bony union or by powerful adhesions, is bettered by a single bath; and in some instances full recovery of the use of an impaired joint will follow the Tallerman treatment alone. There are many other diseased conditions that derive equal benefit from the superheated air, as attested by leading medical men, both in Great Britain and in other countries.—*The Therapist.*

ERYSIPELAS AND ICHTHYOL.—*The Medical Press and Circular* of November 8, 1899, states that a medical confrère has recently published a series of 250 cases of erysipelas treated exclusively with ichthyol; the patients belonged to all grades of society, and their ages varied from six months to eighty-seven years. After having cleaned the surface with a plug of cotton-wool wet with alcohol, he applies with the fingers an ointment of vaselin and ichthyol (13 to 30 per cent). The treatment is renewed every four or six hours. Recovery was rapid in every case. —*The Therapeutic Gazette.*

BEER YEAST IN VAGINAL GONORRHEA.—*The Medical Press and Circular* tells us that Sireday is in the habit of employing in his hospital service beer yeast in the treatment of blennorrhagia in women, according to the method of Dr. Landau, of Berlin, who employed it in leucorrhea. A plug of cotton steeped in a mixture of fresh brewery yeast and sweetened water is introduced into the vagina and renewed daily. The daily treatment brings about a rapid modification of the diseased state of the mucous membrane, and a notable decrease of the secretion, although it does not effect a complete cure.—*Ibid.*

Miscellaneous.

ON THE EFFECT OF CONCENTRATED SUN-BEAMS.—Dr. Carl Gerson, of Berlin, furnishes a contribution to the therapy of concentrated sun-beams in the *Arch. für Lichtherapy, Bd. I., H. 3*, 1899, in which he states that he proceeded from the conviction that the simultaneous influence on the skin of all the light-rays, as nature acts through the sun, being the most rational process, he turned to account not the blue rays alone, but all the rays of the sun.

In order to strengthen the effect, he uses a collecting lens, 9½ centimeters (3¾ inches) in diameter and of corresponding thickness, when he has to treat skin diseases, and holds that lens at such a distance that the contact of the bundle of rays calls forth on the skin a strong sensation of warmth within the illuminated circle. As it is necessary to have said circle under constant control, the author suggests wearing protecting spectacles of smoked glass, or else blue colored glass.

The first experiment Dr. Gerson made on himself in treating a septic ulcer, caused by the infectious sting of some insect, The ulcer was situated over his right wrist and reacted very little to hydrotherapeutic compresses and disinfecting salves. Then Dr. Gerson thought his case would be an appropriate one to try light-therapy. In consequence, he treated the ulcer, continuing compresses and salves, every day for fifteen minutes with concentrated sun-beams. After each sitting he could ascertain a diminution of the secretion of pus, a notable subsiding, or levelling of the edges of the ulcer and a diminution of the inflammatory edema. The painful tension and the fever subsided. After eight sittings, the fundus of the ulcer was clean and covered with sound granulation, filling up in a few days the whole cavity and the covering of the skin set in from the edges.

After this favorable experience, Dr. Gerson has frequently made use, in his polyclinic, of this mode of treatment in eczema, herpes tonsurans, impetigo contagiosa, ulcus cruris, etc., and obtained good results.—*Deutsche Medizinal Zeitung*, No. 11, of February 5, 1900.

Case of General Infection by Influenza-bacilli.—Staff-surgeon Dr. Slawyk reports, *Ztschr. f. Hygiene und Infectionskr., Bd. 32. H. 3.*, the following remarkable case: The patient, a child nine months old, was brought to the hospital with the diagnosis of cerebro-spinal epidemic meningitis. In order to confirm the diagnosis, a lumbar puncture was made, the result of which was surprising. On account of the enormous pressure within the cavity of the head only 3 *c. c. m.* of a bloody, turbid, thin fluid exudate, which stood after settling under an initial pressure of 450 *mm*, was voided. The trifling quantity of the discharged liquid, as well as the remaining tension of the larger fontanelle admitted the *a priori* conclusion that the communication between brain and spinal cord was insufficient, a supposition fully confirmed by the post-mortem examination, on account of the viscous pus found in the brain. The investigation of the exudate obtained by the lumbar puncture showed that it consisted of thin pus. Microscopic examination revealed numerous poly-nucleated leucocytes and between these, partly situated in their protoplasm, there were numerous and very minute formations, looking like diplococci, but under a very strong magnifying power were recognized as extremely tender, bipolar-colored bacilli. The culture process showed that they were influenza-bacilli. The great virulence of the lumbar fluid was interesting. O. 5 *c. c.* of the same, inoculated in a guinea pig, resulted in the death of the animal in convulsions thirty minutes afterwards. On the other hand, a two-days-old blood-bouillon of these bacilli caused death only after three days. After the etiology of the meningitis was recognized, it was easy to prove that the influenza-bacilli were not alone settled in the brain centres, but throughout the whole body. They were numerously established in the pus of an abscess on the external malleolus, and could be cultivated from it. In the blood taken from the tip of the left fore-finger influenza-bacilli thrived. In the left brain-ventricle they were microscopically observed to exist in great quantities, and likewise they were found in longitudinal sections of the lungs, where they lay mostly in the finest bronchi and in the alveoli, within minute corpuscles of pus. They were also cultivated from an abscess situated on the dorsal surface of the right hand. In the secretions of the nose there were none. How the bacillus entered the animal economy of the child Dr. Slawyk was unable to demonstrate. Very likely the bacilli found their way through the lungs, since there were found many of them on the free surface of that organ.—*Deutsche Medizinal Zeitung*, February, 1900.

ARTIFICIAL PRODUCTION OF GOUT.—Dr. H. Kionka, in the *Berl. Klin. Wochenschr.*, has an interesting article on the artificial production of gout. After feeding fowls during several months with nothing else but horse-flesh, freed of fat and sinews, phenomena of true gout set in. Several types of the disease could be distinguished. In one of them the fowl showed an unstable walk, drew its legs towards the body in stepping forward; were attacked from time to time with great weakness in the extremities; showed swollen feet, and soon were unable to move about at all, losing their appetite, became emaciated and died. In these there was but little deposit of urates in the edematous articulations. Strongly developed tophi (chalk stones) at the articulations and between the sheaths of the tendons of the legs were found in another group of fowls which had not such pronounced attacks as those above mentioned. In a third group of fowls the picture of "visceral gout" could be observed with urate-deposits on the serous membranes of the intestines and infarcts of uric acid in the kidneys. The gout-kidney was in general the regular pathologic and anatomic condition in all fowls, which had died, fed by meat only.

The quantity of the secreted excrements, showing an acid reaction, consisted in about 250 to 300 grams, including about 12 to 20 grams of dry matter. On account of the large absorption of food (150 grams of meat, and water *ad libitum*) the nitrogenous secretion was likewise very large, 3.4 to 5.4 grams per day. The excretion of ammonia consisted on an average in 0.3 grams per day. The quantity of the secreted uric acid was remarkable, which fluctuated between 7 and 11 grams daily. The flesh-fed fowls were very greedy for lime. To two fowls Dr. Kionka gave, beside their flesh-food, 10 grams of pulverized eggshell. He observed a great thirst in the fowls, besides an increase of over 500 grams in the quantity of feces excreted, with 30 grams of dry mater, which excrements now showed an alkaline reaction. There was also an increased excretion of ammonia and a lowering in the excretion of uric acid, which now showed only 3.5 to 6 grams per day.

SMALLPOX AND VACCINATION.—At the recent meeting of the Louisiana State Medical Society, Dr. F. J. Myer, of Opelousas, read an able paper on Variola, as the chairman of the section on quarantine. "Over a century has elapsed since the immortal Jenner, after twenty years of thought and labor, gave to the world the discovery which was destined not only to rob of its terrors, but absolutely stamp out (when intelligently applied) a hideous disease, whose origin is lost in the obscurity of antiquity. According to eastern tradition it long ante-dated the Christian era, was referred to in the writings of Philo, in the last century, and accurately described. A disease which Macauley, the historian, called 'the most terrible of all the ministers of death,' because prior to vaccination it had decimated Europe, South America, Mexico, and from Greenland's icy mountains to India's coral strands it left the indelible footprints of its disastrous march, and mowed down a wide swath of death.

"In the graphic language of Macauley: 'Small-pox was always present, filling the churchyards with corpses, leaving on those whose lives it spared the hideous traces of its power.' And yet, after all these years, with the statistics before us which show that in Berlin the mortality from variola for the quarter century preceding the practice of vaccination amounted to 3422 per 1,000,000 living inhabitants, and was reduced to 176 per 1,000,000 in the forty years after vaccination was practiced; one-tenth of all the mortality prior to vaccination in the German cities was from variola, and every third to fifth year it assumed epidemic proportions, when the mortality rose to 50 per cent. In London the mortality before vaccination was 9 per cent: after compulsory vaccination was enforced it was reduced to 0.6 per 100,000; while in Paris, where the climatic and topographic conditions are superior to London, but where vaccination is not as rigidly enforced, the mortality runs from 1.36 to 10.1 per 100,000. In New York, prior to 1876, the mortality from variola (Cyrus Edson) amounted to 59.57.

"Since then, owing to the effective work of the vaccination corps, the mortality has been reduced to 8.38 per 100,000; in like manner the mortuary records of every country on the globe teem with instances of the prophylactic value of vaccination and revaccination, and of the value of modern methods of isolation and disinfection of families in stamping out variola, and yet to-day in this State we are confronted with a widespread epidemic of variola, which, though discrete, may, under favorable conditions, assume a malignant type and exhibit the 29 per cent. mortality that New Orleans, with shame, confesses, an epidemic which might easily have been extinguished in its incipiency, but which has been allowed to grow until it has assumed such proportions in some localities that it would be useless to isolate, for the State could not stand the expense; while here in New Orleans, a city with 300,000 people, ever ready with lavish hand to pour out money for a Carnival parade, does not yet possess a hospital for consumptives, nor any other contagious or infectious disease hospital, but merely a pest camp, where the unfortunate victims of variola are farmed out at a price that is a premium on death, and which if we are to take the testimony of grand juries, the public press and victims who have survived its horrors, is a place across whose gloomy portals is inscribed the sinister legend: 'Who enter here leave hope behind.'

"Is our civilization a failure or is the Caucasian played out? The disease is with us. It is incumbent, therefore, on the medical fraternity to do their share, individually and collectively, to remedy the existent evils and to restrict, limit and stamp out this pest.

"It seems almost a work of supererogation to rehearse these elementary truths, and yet we daily see infractions practiced monumental in their stupidity, and accountable for a large percentage of the bad arms that have thrown such discredit on vaccination and the prejudice excited in the minds of the laity. I fully agree with Dr. Dyer that vaccination is a surgical procedure, every step of which should be approached with aseptic precaution. If this was religiously done, from the cleansing and disinfection of the area to be scarified to the time when the scab falls, the vesicle in the interval being protected with a vaccine shield, which would prevent both mechanical injury and the entrance of atmospheric germs, few bad arms would result.

"We can not too severely condemn the cutting and slashing and bleeding which inexperienced vaccinators, through ignorance or hurry, resort to in vaccinating, instead of gently laying bare over a diminutive area the fine network of capillary vessels. Nor can we too severely condemn the growing practice of vaccinating ladies on the leg. The application of any dressing which will soften the capsule destroys its natural protective covering. We should insist on the teaching of the older practitioner of infant vaccination, revaccination at puberty and whenever variola breaks out in the immediate community, and should educate public sentiment up to the necessity of compulsory vaccination, and to view it not as a curtailment of any of the personal rights of the citizen, but as a protection offered society against a dangerous nuisance. The establishment of a vaccine farm or farms at convenient points throughout the State would go a long way in breaking down the popular prejudice against vaccination. General Jastremski, formerly consul at Callao, in Peru, relates that such a farm was established at Lima, Peru, and that it did a great deal in breaking down prejudice against vaccination, thousands flocking to the farm to be vaccinated with the freshly drawn lymph who hitherto had dodged the public visco. This, like all questions of public hygiene, will not take root in the minds of the people until they are systematically taught the true value of prevention of contagious and infectious disease. This can only be done systematically by the State. I can not, therefore, too strongly urge upon this honorable body to indorse by formal resolution the demand of the farmers of the State, at their recent agricultural convention in Arcadia, for the creation of a Commissioner of Public Health, whose functions purely educational, should be to hold sanitary institutes in every parish of the State at least once a year.

"The widespread prevalence of variola, the growing danger of yellow fever from our benevolently assimilated dependencies, with its disastrous interruptions to our commerce; the yearly spreading of typhoid, the atrocious drinking water supply of the State, the undrained, unsewered conditions of our towns, the dangers from which, increasing in a direct ratio to the increase in population, makes it imperative to delay no longer the instruction to which the people of the State are entitled."

PATHOGENESIS OF UROBILINURIA.—Dr. Vitali, (*La Clinica Med. Italiana*, 11, 1899,) infers from his clinico-experimental investigations that urobilin is formed in the intestine by transformation of the pigments of the bile. With the chromogen of the intestine it is partly absorbed, finding its way into the liver by the circulation of the portal vein. There it is transformed partly into bilirubin, and partly recarried into the intestine together with the bile, while the chromogen is not retained by the liver, but passes into the urine where it is found normally. Under pathologic conditions, *i. e.*, when the liver cell is altered, or is insuffìcent, the urobilin is no longer transformed but passes for the greater part into the circulation and is secreted by the kidneys.

Considered semiotically, *i.e.*,symptomatically, *urobilinuria* can be designated as the most sensitive index of a functional, or an anatomic alteration of the liver-cell, provided an increased hemolysis and a fecal stagnation of long duration can be excluded.

In the *Deutsche Medizinal Zeitung of* February 11, 1900, Dr. Finder gives an able abstract of Vitali's researches.

LUPUS ERYTHEMATOSUS CURED BY APPLICATION OF ROENTGEN RAYS.—Dr. Schiff and Dr. Freund presented at the Dermatologic Society of Vienna, in December last, a patient who had been treated during one year with the rays of Röntgen.

All the original sites of the disease healed nicely, but recently there occurred in their vicinity appearances which might (and perhaps ought to) be considered as a recurrence after complete recovery.

There was likewise, in the neighborhood of the originally affected parts, a small zone where alopecia, or more or less advanced baldness, had developed since the treatment was begun.

Drs. Schiff and Freund were of the opinion that this baldness was due to the fact that at the time the treatment commenced there were no protecting masks in use, and the adjacent sound parts were irradiated by the rays as well as the diseased parts proper.—*Deutsche Medizinal Zeitung*, No. 9, 1900.

SIPHON PUNCTURE IN ABDOMINAL OPERATIONS.—Lauenstein (*Centralbl. f. Chir.*, No. 23, 1899; quoted from the *British Medical Journal*, Nov. 18, 1899) describes a combined method of puncture and siphon action, which he had found very useful in operations on ovarian cysts and distended gall-bladder. This method consists in the connection with the penetrating cannula of a long elastic tube filled with sterilized or aseptic fluid, which is allowed to flow away, and thus to establish a siphon action at the moment the canula enters the cyst. By this method the surgeon may prevent a discharge of the contents of the cyst into the peritoneal cavity, and also avoid dragging the ovarian tumor through the external wound, during which air often enters into the abdomen. Much importance is attached to the application of this method to operations on the gall-bladder, as it is very necessary to prevent discharge into the abdominal cavity not only of any purulent contents, but also of clear and normal bile, which the author has found by frequent bacteriologic investigation may contain both the bacterium coli and streptococci. Siphon puncture has also been found serviceable in certain operations on the stomach, in the course of which it becomes necessary to remove rapidly and safely a quantity of retained fluid from this organ.

STERILIZATION OF CATGUT BY ALCOHOL.—Bard (*Gazette des Hôpitaux*, November, 1899) sterilizes catgut in alcoholic vapor raised to 125 deg. C. This makes the catgut seem stiff, but before use it is soaked in eighty-per-cent. alcohol. It is very strong, holds its knot, and completely disappears in the tissues in eight days

A CURIOUS CONCEPTION.—A woman named Akroyd, says *The Barrister*, was tried before the Court of Queen's Bench in Dublin for refusing to produce a child which she had abducted. Some amusement was created in court when the prisoner was sentenced to six months, without hard labor, in Richmond prison, which is only for the incarceration of males. Carved in the stonework over the main entrance to the prison are the following words: "Cease to do evil, learn to do well." The commitment was the subject of the following lines:

> In most earthly tribunals some harshness prevails,
> But the Court of Queen's Bench is both prudent and mild;
> It committed Miss A. to the prison for males,
> As the readiest mode of producing a child.
> How she'll do so surpasses conception to tell,
> Should she "cease to do evil, and learn to do well;"
> And if in six months, without labor confined,
> She produces a child, she'll astonish mankind.

Medical News Items.

THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS met in Washington, May 1, 2 and 3. The general sessions were held in the afternoons at the Lafayette Square Opera House and were well attended. The papers of Dr. Bowditch on Medical Education, Dr. Cabot on Bacteriology and Clinical Medicine, and the magnificent poem by Dr. Weir Mitchell, "The Physician," were notably well received. On the second night a handsome reception was given by the president of the Congress, at the Arlington Hotel. The banquet was held at the same hostelry on the night of the last day of the meeting.

The several sections or associations were well attended; New Orleans was represented in the American Laryngological by Dr. A. W. De Roaldes; in the American Surgical by Drs. E. Souchon and R. Matas, and in the American Dermatological by Dr. Isadore Dyer. In all there were nearly seven hundred members of the congress present.

The work of each association was necessarily technic; but in some, subjects of general interests were under discussion.

In the American Dermatological Association, Dr. Morrow, of New York, read an able paper on the "Prophylaxis and Control of Leprosy in the United States." He discountenanced the alarmist method, but urged agitation of more general knowledge of the need of some action. After reviewing the efforts of the 1894 Congress of Physicians and Surgeons, and what had been done since then, the writer took up the present situation.

The new possessions, particularly the Philippines, threaten, and whatever doubt there may be of the contagious activity of leprosy when transplanted to this country, there can be no question of the ultra-contagiousness in these tropical islands. The lepers of Southern and Central Europe have been wholly recruited from the ranks of sailors and soldiers and those of official rank who have sojourned for a longer or shorter time in leprous countries. Of 100 cases of leprosy observed in Great Britain in 10 years, all, with possibly 2 exceptions, have contracted the disease in the leprous colonies of England. Olivade states that 500 of 1500 cases in Spain were soldiers or monks, who contracted the disease in the Philippines, Canaries or in Cuba.

The Chinese have been the most active in spreading this disease in modern times. Canthie strongly argues the spread of leprosy through coolies of the Malay Peninsula, Dutch, Spanish and Portugese, East Indies, Oceanica, Fiji, New Caledonia, Hawaii and the West Coast of Africa. In New York and San Francisco the Chinaman is the dominant leper. The leprosy of the United States, with the exception of Louisiana, is largely a foreign product, ingrafted by immigration, and it is impossible to destroy the growth within our borders if it is continually nourished by transplantation from without.

The prevention can be accomplished—

(1) By excluding leper immigrants.

(*a*) By international co-operation to provide examination of emigrants before embarking.

(*b*) Immigrants of leprous families and from leprous districts should be registered and kept under observation.

2. By careful examination of returning soldiers and civilians who have for long sojourned in leprous colonies.

3. Seaboard and rigid land quarantine at Mexican and Canadian borders.

4. By the employment of skilled experts as quarantine inspectors. Hitherto knowledge of skin diseases has not been a prerequisite to office.

In considering the control of leprosy in the United States, the writer carefully related the facts that there were numerous known foci; the actual number of cases of leprosy was unknown; the disease readily lends itself to concealment, as the badge of leprosy is as degrading to-day as in medieval times.

As regards our health authorities, it may be said that no organized or systematic effort has been made for the control of leprosy in the United States. Louisiana is the only State in the Union which has provided a special asylum or lazaretto for the reception and care of the leper population. Although the provisions of the act creating this institution make it obligatory that all persons in the State afflicted with the disease should be isolated therein, the policy of segregation has proven a comparative failure.

Dr. Dyer states that "the legislation as it stands is quite sufficient for all purposes, but it fails of efficacy for several reasons:

1. The board is made up largely of laymen who have no conception of the hospital necessities and who have fulfilled the law creating them only in so far as they have provided an asylum for such lepers as may choose or may be persuaded to take refuge there.

2. The physicians of Louisiana are blind to the urgency of reporting cases of this disease, or they, like myself, are unwilling to send any patient to the home to die, without treatment, which is amenable to medical care if not cure."

"It is my opinion that the question of leprosy control in Louisiana is as yet unsolved. During the existence of the leper home, there have been, to my knowledge, over 150 lepers at large, while only about 30 have been in the home."*

Other states than Louisiana have included leprosy under the laws governing contagious diseases. California has been rigorous in putting lepers in the pest house.

New York authorities have been inconsistent and in degree capricious in first housing and segregating and then setting free its lepers. While no indigenous leprosy can be noted in New York, the overwhelming clinical evidence elsewhere points to the contagiousness of the diisease.

"The infection of a community with leprosy, like that of an individual, usually exhibits a prolonged incubatory phase.

"Twenty-five years ago not a half-dozen lepers could be found in the State of Louisiana and the disease was regarded as practically extinct—over 300 cases have been recorded since that time. What has happened in Louisiana may happen in New York or elsewhere.

"My own impression is that leprosy is slowly gaining ground in this country. The New York Dermatological Society in the five years just past has recorded more cases than in twenty-six years previous. Two indigenous cases were presented within the past few months.

"The policy pursued by the State and city of New York must be condemned for the results. Inaction or a pest house has been the rule."

"To accomplish anything, concerted action is essential. The irregular distribution of the disease and the cost of isolating a few forbid proper attention otherwise.

"The control of leprosy should be committed to the National

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*Since this time, the report of the Leper Board states that a total of 45 have been admitted, with 13 dead and two who have left the home, leaving 30 present inmates.—*Ed.*

Government. Isolation and segregation, under proper provisions, should obtain.

"The proper diagnosis should be made, for the consequences of a mistaken diagnosis are of such vital import that to prevent such a miscarriage, a board of competent experts, selected for their skill in the diagnosis of the disease, should be appointed and the verdict of leprosy should not be pronounced or accepted as final unless confirmed by such board.

"Intelligent discrimination should be exercised in the selection of cases suitable for segregation. I am not prepared to subscribe to the dictum that every leper, whenever and wherever found, should be summarily seized under government edict and confined until he dies, nor that the enforcement of segregation and isolation should be absolute and implacable. There is no reason to fear that the anesthetic leper, in whom the bacilli are few and deeply lodged in the nerves, with no chance of their elimination through broken or ulcerative surface, will communicate the disease."

Suggestions were embodied covering home segregation for the well-to-do, and free colonization for those confined in a national asylum, should there be one.

THE MEMPHIS LANCET has consolidated with the *Memphis Medical Monthly*, and in deference to the seniority of the latter journal, the name of the new journal will be "*The Memphis Medical Monthly.*" We felicitate the management of the joint journal on their wisdom and wish them success.

THE STATE BOARD OF HEALTH OF MISSISSIPPI adjourned after a busy meeting recently. Out of 101 applicants for the license to practice medicine, only forty-nine passed. A motion was adopted requiring two-thirds of the board to be present to pass an applicant for license to practice medicine, and the following resolution was adopted:

"*Resolved*, That the Board of Health instruct the county health officers that the practice of osteopathy and magnetic healing are in direct violation of the laws regulating the practice of medicine in the State of Mississippi, and that they report all parties practicing such in their counties to the grand jury, district attorneys and circuit judges and the secretary of the State Board of Health; further, that they report all parties practicing medicine without license, and request the circuit judges of the various districts to embrace this in their charges to the grand juries."

CROWLEY'S HEALTH BOARD IS ACTIVE in cleaning up that town, as the following attests:

OFFICE OF BOARD OF HEALTH,
CROWLEY, La., May 5, 1900.

DEAR SIR,—You are hereby requested to place your entire premises in a sanitary condition as follows: Thoroughly cleanse all cesspools, privies, privy vaults, by the burial of all refuse matter and the free use of lime and copperas, etc. Also open all drains leading to street drains and disinfect same as above described. Also burn all garbage, and what will not burn must be buried. The above instructions must be complied within five days after the service here. Fail not under penalty of the law. By order of

BOARD OF HEALTH.

H. W. CARVER, *Secretary.*

THE NEW ORLEANS SMALL-POX ISOLATION HOSPITAL is yet a castle in Spain, and the fact that the present contractor has received a new temporary contract points to the probable oblivion into which the castle will fall.

THE EYE, EAR, NOSE AND THROAT HOSPITAL administrators elected their officers in May; Mr. Frank Barker, a long-time friend and trustee of the institution, was made president. The other officers were then chosen as follows: First vice president, Gen. W. G. Vincent; second vice president, Mr. Hypolyte Laroussini; treasurer, Mr. W. R. Stauffer; secretary, Mr. Joseph A. Hincks.

THE UNIVERSITY MEDICAL MAGAZINE has passed under the entire control of the University of Pennsylvania. The new management announces liberal expansion of the work hitherto embraced in the scope of the publication.

DR. S. L. POWLETT, of Hammond, has been elected coroner of Tangipohoa parish.

THE WM. S. MERRELL CHEMICAL COMPANY have opened in New Orleans a Southern department of their wholesale drug business. With Parke, Davis & Co. also, New Orleans now has two well known concerns distributing from this point.

The American Medical Editors' Association will hold their annual banquet at the Hotel Dennis (headquarters for the approaching annual meeting of the A. M. A. June 5-9), Atlantic City, N. J., on the evening of Monday, June 4.

The International Congress of The Medical Press.—Among the numerous medical, semi-medical and quasi- medical gatherings to be held in Paris this year, that of the medical press is announced. The idea appears to have emanated from the meeting of the International Congress of Medical Sciences in Rome, 1894

The notice of the meeting is quite complete and outlines the matters to be discussed. Contributions to the program are invited to be sent to Dr. Blondel, 8 *rue de Castellane*, Paris.

The meeting is to begin July 26 and will last three days. The subjects announced embrace the technic of Medical Journalism and Special Deontology in the Medical Press. A complete publication of the transactions is to be made and sent to members of the congress. Membership is $5 (25 francs) for editors and those actually connected with the journal, and $2 (10 francs) for others.

The Louisiana State Pharmaceutical Association met the last of April in New Orleans. After a successful session the following officers were elected for the ensuing year: President, M. Bernstein, of Shreveport; first vice president, Miss Corinne Wright, of New Orleans; second vice president, Miss Rosalie Cook, of New Orleans; corresponding secretary, Miss F. V. Yeager, also of New Orleans; recording secretary, W. P. Duplantis, and Treasurer, Geo. L. Brown, both of New Orleans.

Married.—A very pretty wedding was celebrated in New Orleans on April 24, at the home of the parents of the bride, Miss Alys Laroussini, who was married to Dr. Emanuel J. Senn, of Chicago. The groom, the son of Dr. Nicholas Senn, carried not only one of the lights of New Orleans' Creole coterie but also the felicitations of the host of medical friends he left behind.

Dr. Edwin A. Alderman has accepted the election to the presidency of Tulane University. Dr. Alderman has been active in administrating a like office at the University of North Carolina.

The Thirty-Third Annual Meeting of the Mississippi State Medical Association was held at Meridian, Miss., May 16 to 19. Considering it was a postponed meeting, on account of the high water last month, it was well attended, especially by the younger members, a larger number being in attendance than at an any other previous meeting. The President, Dr. R. E. Jones, of Crystal Springs, gave a fine address, containing many practical suggestions for the elevation of the medical profession. He is in favor of establishing a special preparatory class for students at the State University who intend to take a medical course. Dr. Jones is in favor of a State law requiring a diploma from a reputable medical college before the applicant can come before the State Board of Medical Examiners.

An important change was made in the constitution, doing away with the committee and electing the officers by the members of the association.

Dr. H. M. Folkes, of Biloxi, Miss., introduced the following resolution, which was enthusiastically endorsed: "Resolved, That the Mississippi Medical Association heartily endorse the recent action of the State Board of Health, in beginning a crusade against such quacks as magnetic healers, osteopaths, etc., and heartily pledge ourselves to assist therein to the fullest extent."

It was resolved that white women who are qualified may become members of the association. Dr. H. A. Minor, of Macore, Miss., was elected President for the following year.

The social features were a banquet, by the local profession, at the Southern Hotel, and a visit to the Arundel Lithia Springs, by invitation of Hon. G. Q. Hall, the proprietor, where a delightful luncheon was served and the doctors were given an opportuuity to test the virtues of the health-giving lithia water. The young ladies of Meridian assisted in the entertainment. A good band was in attendance and a fine afternoon was pleasantly and profitably spent.

Dr. W. S. Bickham, formerly of New Orleans, was recently elected instructor in surgery in the New York Polyclinic. Dr. Bickham is now associated with Dr. John A. Wyeth in this school. The Journal extends best wishes to the doctor in his new field.

The Name of the Alabama Medical and Surgical Age will be *The Alabama Medical Journal*, beginning with the May issue, 1900. This change is made because it is shorter, and suits the editor and a large number of subscribers and patrons better.

Of Medical Interest —Two bills have been introduced in the Louisiana Legislature of interest to the profession.

The Wimberly bill, in its arrangement amending the medical practice act so that those eligible to practice under the law of 1882 may register now and so qualify, in purpose aims at so emasculating the act as to make it practically repealed.

The Henry bill proposes the creation of a Commissioner of Hygiene, who shall provide lectures and other instruction on sanitary matters at all of the public institutions of education in the State.

Obituary.—Dr. Fessenden Nott Otis, of New York City, died on May 24, at the New Orleans Sanitarium in this city, at the advanced age of 75 years. The doctor had been spending the winter South when an attack of pneumonia confined him to his bed. While convalescing, a carbuncle of the back developed which, in spite of all efforts, caused his death. Dr. Otis was one of the foremost men in the medical profession for the past quarter century. For some time Professor of Surgery at the College of Physicians and Surgeons in New York City, he created special fields of work in surgical procedures, especially of the genito-urinary branch.

Dr. Otis was as well known abroad as at home, and in deploring his death, the Journal condoles with his bereaved family and wishes to add a little voice to the expressions of high appreciation which all medical men owe to his memory.

Dr. J. H. Purnell, of Vicksburg, well known as one of the leading physicians of the State, has returned from a trip to Havana to investigate health conditions. His report has been filed with Secretary Hunter of the State Board of Health. Dr. Purnell says that the government is doing a great work in the way of sanitation. A large number of men, mules and carts are constantly employed in removing the accumulations. An average of 750 loads of refuse is removed daily, four-fifths of which is towed out five miles to sea and emptied into the gulf.

The department is doing most excellent service looking toward the remedying of the insanitary conditions of the interior of the buildings, inspecting the public buildings, hospitals and markets and controlling contagious diseases. A large force of men is employed in a systematic cleansing and disinfection of each domicile, after which the owner is instructed to keep it clean under penalty of a heavy fine. All contagious diseases must be reported to the authorities and an isolation hospital is maintained. Surgeon H. R. Carter, of the Marine Hospital service, is the chief quarantine officer of the Island of Cuba, with headquarters at Havana, where all work pertaining to the prevention and control of infection is done under his personal supervision, which is sufficient guarantee that nothing will be left undone to protect the American shores.

Mr. W. B. SAUNDERS, the well-known publisher of medical books, wishes to announce that he has decided to give recognition to efficient service by associating with himself in business, under the firm name of W. B. Saunders & Company, Mr. F. L. Hopkins, manager of the Subscription Department, and Mr. T. F. Dagney, manager of the Publication Department. They have been connected with the establishment almost from its inception, and to their capable management of their respective departments Mr. Saunders attributes much of the success that has attended his efforts.

Mr. Saunders believes that this action will strengthen the position of the house in the eyes of the medical profession, as it will secure a permanence of organization that will ensure the perpetuation of the business.

The Subscription and Publication Departments will be conducted as heretofore. The Trade Book Department will be under the management of Mr. W. D. Watson, whose connection with the house has extended over the past eight years, and who has demonstrated his ability to manage that department.

THE NEW ORLEANS TRAINING SCHOOL FOR NURSES is to graduate a class of nine nurses on June 1. The commencement will be quietly conducted at the Training School, where the nurses will give a reception to their friends after the exercises.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diseases of Children. By GEO. M. TUTTLE, M. D. Lea's Series of Pocket-Text-Books. Lea Brothers & Co., Philadelphia and New York, 1900.

As stated in the preface, this book was written for beginners in the study of pediatrics, and, as the heading indicates it, the work is an epitome of other excellent text-books, such as the treatise of Holt. It is properly speaking a memorandum to be consulted in a hurry by practitioners, without being disappointed. Besides the conciseness of the text, which is an attraction, the work presents some material advantages. In the first place, the paper and print are very good; next, the monochrome showing Koplik's Spots, the pathognomonic sign of measles and an ordinary aphthous spot for differentiation is very instructive; finally, the type varying in size and bulk for the text, headings, divisions and subdivisions makes the reading of the book so much easier. This manual deserves approbation. DUPAQUIER.

PUBLICATIONS RECEIVED.

A Handbook for Nurses, by J. K. Watson, M. . D.—W. B. Saunders, Philadelphia, 1900.

Essentials of Diagnosis, by Solomon Solis-Cohen, M. D., and Augustus A. Eshner, M. D.—*Illustrated.*—W. B. Saunders, Philadelphia, 1900.

The Refraction of the Eye, by Gustavus Hartridge, F. R. C. S. —P. Blakiston's Son & Co., Philadelphia, 1900.

Transactions of the American Dermatological Association, 1899, by George Thomas Jackson, M. D., Secretary.—Concord, 1900.

International Text-Book of Surgery, by American and British Authors, Edited by J. Collins Warren, M. D., and A. Pearce Gould, M. S., F. R. C. S., Vol. I.—W. B. Saunders, Philadelphia, 1900.

Paralytic Deformities of the Lower Extremities, by E. Noble Smith, F. R. C. S.—Smith, Elder & Co., London, 1900.

Pathology and Surgical Treatment of Tumors, by N. Senn, M. D.—W. B. Saunders, Philadelphia, 1900.

Charbon (*Anthrax*), issued by the State Board of Agriculture and Immigration, Baton Rouge, La., 1900.

Proceedings of the Philadelphia County Medical Society, March, 1900.

Chemistry and Physics, by Walton Martin, M. D., and William H. Rockwell, Jr., M. D.—Lea Bros. & Co., Philadelphia and New York.

The Treatment ot Fractures, by Charles Locke Scudder, M. D. —W. B. Saunders, Philadelphia, 1900.

REPRINTS.

Non-Malignant Gastric and Duodenal Ulcers, by Thomas E. Satterthwaite, M. D.

Puerperal Eclampsia and Its Treatment, by J. T. McShane, M. D.

A New Method of Diagnosis of Tuberculosis of the Kidney.—Remarks on Extra-Uterine Pregnancy.—Remarks on the Influence of Technique upon the Results of Closure of Wounds of the Abdominal Wall.—Remarks on Nephrectomy, With a Plea for the More Certain and Earlier Diagnosis of Conditions Requiring It, by Charles P. Noble, M. D.

A Contribution to the Surgery of the Common Bile-Duct.—Stricture of the Esophagus as a Complication and Sequel of Typhoid Fever.—Report of a Case Cured by Abbe's Operation.—What Should be the Position of the Surgeon Relative to the Treatment of Appendicitis, by J. E. Summers, Jr., M. D.

A Few of the Clinical Uses of Liquid Air, by C. T. Pearce, M. D.

The Nerve Mechanism of the Pelvis and Associated Regions.—The Vagina, Descriptive and Applied Anatomy, by Byron Robinson, M. D.

The Modern Treatment of Stricture, Prostatitis, Urethritis and Cystitis, by G. W. Overall, M. D.

The American Negro, His Past and Future, by P. B. Barringer, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR APRIL, 1900.

CAUSE.	*White*	*Colored*	*Total*
Fever, Malarial (unclassified)		2	2
" " Intermittent			
" " Remittent	4		4
" " Congestive	1	2	3
" " Typho	1	1	2
' Yellow			
" Typhoid or Enteric	3	4	7
" Puerperal		2	2
Influenza	1	2	3
Measles		2	2
Diphtheria	1		1
Whooping Cough		1	1
Apoplexy	11	4	15
Congestion of Brain	2	1	3
Meningitis	7	4	11
Pneumonia	16	24	40
Bronchitis	14	10	24
Cancer	8	1	9
Consumption	30	47	77
Bright's Disease (Nephritis)	20	13	33
Uremia	1	1	2
Diarrhea (Enteritis)	9	10	19
Gastro-Enteritis	4	4	8
Dysentery	3	1	4
Hepatitis	3	1	4
Hepatic Cirrhosis	3	1	4
Peritonitis		1	1
Debility, General	1	2	3
" Senile	18	4	22
" Infantile	3	4	7
Heart, Diseases of	35	21	56
Tetanus, Idiopathic			
" Traumatic	1	2	3
Trismus Nascentium	4	8	12
Injuries	16	10	26
Suicide	2	1	3
All Other Causes	100	130	230
TOTAL	322	321	643

Still-born Children—White, 23; colored, 9; total, 32.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.40; colored, 42.70; total, 25.72.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	29.97
Mean temperature	69.
Total precipitation, inches	10.69

Prevailing direction of wind, southeast.

② 4

FOR REFERENCE

NOT TO BE TAKEN FROM THE ROOM

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